

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

69T6

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

09170

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hosp</u>				STREET ADDRESS (If rural give location) <u>606A Western Circle</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Baby Boy</u> (Middle) <u>James</u> (Last) <u>Ames</u>				(Month) <u>9</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>9-19-55</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>none</u>				14. MOTHER'S MAIDEN NAME <u>Wid. A Virginia Ames</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
762.0 IMMEDIATE CAUSE (A) <u>atelectasis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>9/19/55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/19/55</u>, to <u>9/19</u>, 19<u>55</u>, that I last saw the deceased alive on <u>9/19</u>, 19<u>55</u>, and that death occurred at <u>5:23</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md</u>		DATE SIGNED <u>9/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>		DATE THEREOF <u>9-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		LOCATION (city, town, or county) (State) <u>Salisbury, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS	
DATE <u>9-21-55</u>							

CERTIFICATE OF DEATH

10170

BUREAU V. 2

SEP 23 1955

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

09171

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		2 yrs		TOWN <u>Snow Hill</u>		23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Dighton Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Fred</u> <u>Anthony</u>				<u>9</u> <u>12</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Col.</u>	<u>Widowed</u>	<u>10/30/1887</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Unknown</u>			<u>- -</u>		<u>North Carolina</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Walter Anthony</u>				<u>Sallie Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>Unk.</u>					<u>Hospital records</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>4 days</u>	
<u>022X</u> IMMEDIATE CAUSE (A) <u>Ruptured aneurysm of left subclavian artery</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Syphilis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>9/30/53</u> to <u>9/12/55</u>, that I last saw the deceased alive on <u>9-12-55</u>, and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R.J. Gore, M.D.</u>				ADDRESS (Street, city, town, state) <u>Deer's Head Hospital, Salisbury, Maryland</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 16/55</u>		<u>Baptist Cemetery</u>		<u>Snow Hill</u>	
24. REC'D-BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>SEP 14 1955</u>		<u>Mary H. Hollaway</u>		<u>Walter E. Dennis, Snow Hill, Md</u>		<u>Md</u>	
DATE							

1911

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Religion	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Justice	

BUREAU V. 1

SEP 15 1955

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

09172

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill</u> 23X-2 STREET ADDRESS (If rural give location) <u>RT. # 2</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Ayres</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>September 14-1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>September 14 1955</u>	9. AGE last birthday yrs. Months Days <u>6</u> <u>10</u> <u>9</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Benjamin Franklin Ayres</u>				14. MOTHER'S MAIDEN NAME <u>Ella Cordelia Milbourne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 762.5 IMMEDIATE CAUSE (A) <u>Anoxia</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>9/14</u> , 19 <u>55</u> , to <u>9/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/14</u> , 19 <u>55</u> , and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md</u>		DATE SIGNED <u>9/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>9/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Md</u>	
24. REC'D BY REGISTRAR DATE <u>9-16-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS	

2195252260

101132

CERTIFICATE OF DEATH

MD 101132

DATE OF DEATH

[Faint, illegible handwritten text in the main body of the certificate, likely containing personal and medical details.]

BUREAU V. 2

SEP 19 1955

RECEIVED

INSTRUCTIONS

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9205

CERTIFICATE OF DEATH

09173

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Delmar		50 yrs		TOWN Delmar		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
6 W. State Street				6 W. State Street			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
William Joseph Benson				Sept. 5 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
Male	White	Married	Oct. 19, 1869	85			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Janitor		School		Sussex County, Del.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Benson				Jane Elliott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Ida Benson, Delmar, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
Coronary Thrombosis						6 hours	
ANTECEDENT CAUSE(S) DUE TO (B)						5 weeks	
Coronary Thrombosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						10 yrs	
Arteriosclerosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 31, 1952, to Aug 5, 1955, that I last saw the deceased alive on Aug 4, 1955, and that death occurred at 6 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
A. H. Lynch				M.D.		Aug 7 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9-7-55		Mt Olive		Delmar, Del.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE		Sept. 8, 1955		Mary H. Holloway		W. S. Spaulding, Delmar, Del.	

CERTIFICATE OF DEATH

1913

Reg. No. 10

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Date of death

5. Time of death

6. Cause of death

7. Place of death

8. Signature of physician

9. Name of informant

10. Address of informant

11. Date of registration

12. Signature of registrar

13. Signature of medical examiner

14. Signature of coroner

15. Signature of health officer

16. Date of death (Month, day, year)

17. Time of death

18. Name of informant

19. Address of informant

20. Name of informant

21. Address of informant

22. Name of informant

23. Address of informant

24. Name of informant

25. Address of informant

BUREAU V. S.

SEP 11 1913

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH

1. Name of deceased (Print or write full name)
2. Sex
3. Age
4. Date of death
5. Time of death
6. Cause of death
7. Place of death
8. Signature of physician
9. Name of informant
10. Address of informant
11. Date of registration
12. Signature of registrar
13. Signature of medical examiner
14. Signature of coroner
15. Signature of health officer
16. Date of death (Month, day, year)
17. Time of death
18. Name of informant
19. Address of informant
20. Name of informant
21. Address of informant
22. Name of informant
23. Address of informant
24. Name of informant
25. Address of informant

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9162

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09174 Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place) All life		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - 503 W. Isabella St.				STREET ADDRESS (If rural, give location) 503 W. Isabella Street			
3. NAME OF DECEASED: (Type or Print) Frederick Douglass Black				4. DATE OF DEATH (Month) 9- (Day) 17- (Year) 1955			
5. SEX: M	6. COLOR OR RACE: C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Infant	8. DATE OF BIRTH: 8-27-55	9. AGE last birthday: IF UNDER 1 YEAR Months 25 Days 20		IF UNDER 24 HRS. Hours 20 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Baby		10b. KIND OF BUSINESS OR INDUSTRY: Baby		11. BIRTHPLACE (State or foreign country): Salisbury, Wicomico Co. Md.		12. CITIZEN OF WHAT COUNTRY? Baby	
13. FATHER'S NAME: Donald Purnell				14. MOTHER'S MAIDEN NAME: Beverly L. Black			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Baby		(If Yes, give war or dates of service) Baby		16. SOCIAL SECURITY No.: Baby		17. INFORMANT & ADDRESS: Salisbury, Md. Beverly L. Black, 503 W. Isabella Street	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
500X Immediate cause (a) Acute tracheo-bronchitis. DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						Sudden.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Earl L. Royce				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> 9-20-55			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 9-20-55		NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		LOCATION (City, town, or county) (State) Fruitland, Wicomico Co., Md.	
DATE REC'D BY LOCAL 9-21-55		REGISTRAR'S SIGNATURE Mary W. Holloway		24. FUNERAL DIRECTOR Mary A. Stewart ADDRESS 324 E. Church Salisbury, Md.			

15100

Wisconsin

Madison

Madison

Bellevue

All life

Bellevue

100 W. Lombard Street

At home - 100 W. Lombard St.

Madison

Madison

30

3-27-57

Copy

Bellevue, Wisconsin Co. 100

Copy

Copy

Reverly, N. H.

Reverly, N. H.

Bellevue, Wis.

Reverly, N. H., 100 W. Lombard Street

Copy

Copy

Copy

BUREAU V. E.

APR 23 1957

RECEIVED

U. S. Navy Secretary

U. S. Navy Secretary

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

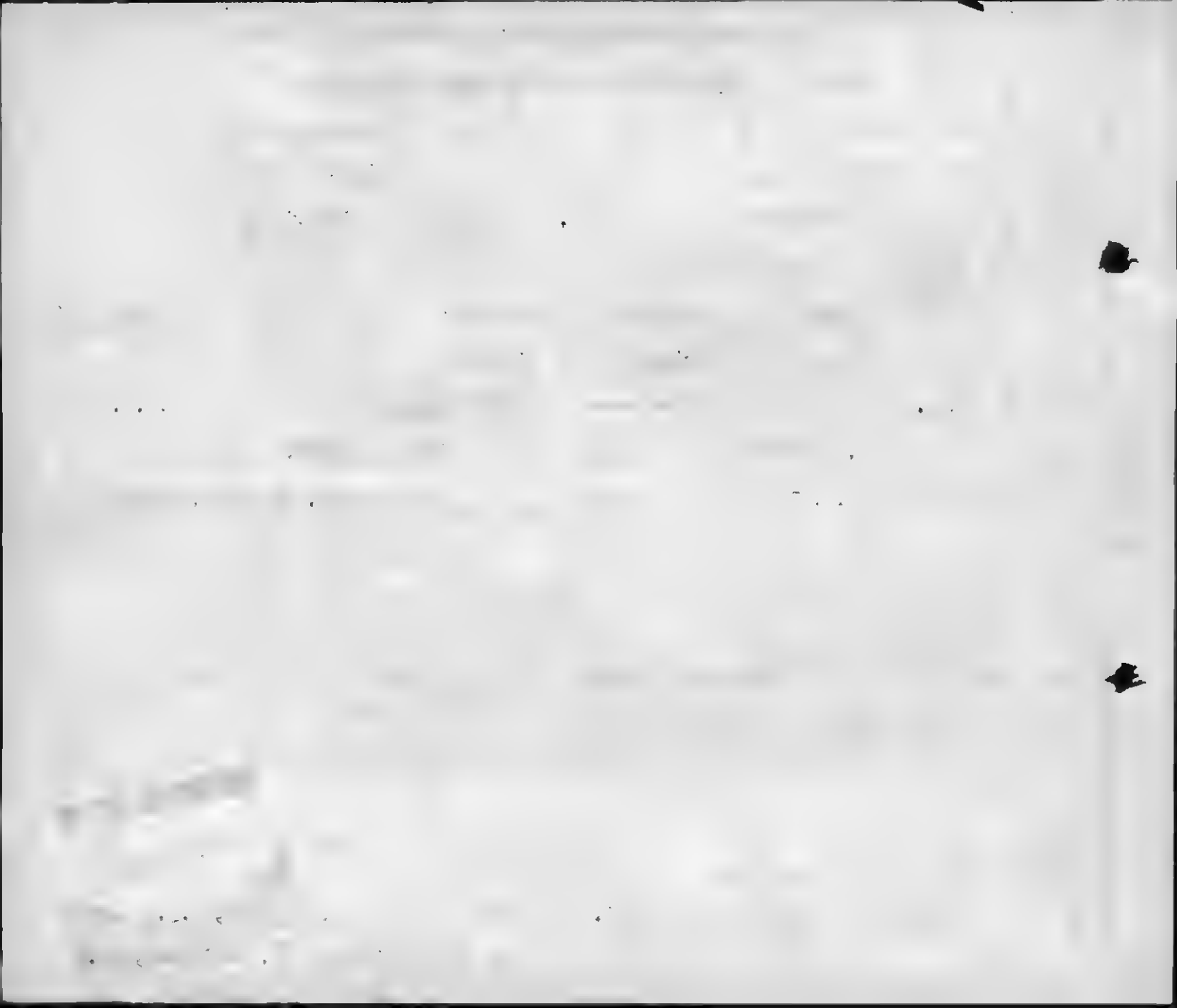
09175

9206

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Pittsville</u>		<u>4 Yrs.</u>		TOWN <u>Pittsville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pittsville</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MERRITT GOODRICH CHAMBERS</u>				<u>9 10 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>May 30, 1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Ret. Doctor</u>			<u>Medicine</u>		<u>New York</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William G. Chambers</u>				<u>Martha Hackett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>Yes</u>			<u>None</u>		<u>Mrs Helen H. Chambers, Same</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-10-55</u> , to <u>9-10-55</u> , that I last saw the deceased alive on <u>9-10-55</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Will H. Standley</u>				ADDRESS (Street, city, town, state) <u>6045 Church Ave. Md 21043</u>			
DATE SIGNED <u>9-10-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>9/14/55</u>		<u>Wm J. Lee Crematory</u>		<u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Mary H. Holloway</u>		<u>The Hill & Johnson Co. Salisbury, Md.</u>			
DATE				<u>Norman T. Baker</u>			



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9163

CERTIFICATE OF DEATH

09176

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		4½ months		OR TOWN <u>Tyaskin</u>		X	
HOSPITAL OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>RFD # 1</u>			
3. NAME OF (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>EZRA</u> <u>BARTLEY</u> <u>CHARLES</u>				<u>9</u> <u>22</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Jan. 8, 1892</u>	<u>63</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>		<u>--</u>		<u>North Carolina</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>				<u>Hospital Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
42-1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						<u>5 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>11 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 3</u> , 19 <u>55</u> , to <u>Sept. 22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 22</u> , 19 <u>55</u> , and that death occurred at <u>9:10AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>V. Juerman</u> <u>V. Juerman, M.D.</u>				ADDRESS (Street, city, town, state) <u>Deer's Head Hospital</u> <u>Salisbury, Maryland</u>			
				DATE SIGNED <u>9/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 25, 1955</u>		<u>Gilford Memorial Park Cem.</u>		<u>Gilford County N. Carolina</u>	
24. REGD BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Sept. 26, 1955</u>		<u>Mary J. Holloway</u>		<u>HOLLOWAY & COMPANY</u>		<u>SALISBURY MARYLAND</u>	



9164

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 <u>SALISBURY</u>				<u>Selbyville</u> <u>46X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>PENINSULA GENERAL HOSPITAL</u>				<u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Cobb</u>				OF DEATH <u>September 7 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>White</u>		<u>September 6-55</u>	yr.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>RALPH DELMAR COBB.</u>				<u>JEANETTE BERTHA Mc GEE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
7640 IMMEDIATE CAUSE (A) <u>Fetal anoxemia with</u>						<u>unknown</u>	
ANTECEDENT CAUSE (B) <u>malnourishment of fetus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Kinking of cord</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>distress of MB.</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/6/55</u> to <u>9/7/55</u> that I last saw the deceased alive on <u>9/7/55</u> , 1955, and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>A. W. Sunderman</u>				ADDRESS <u>966 N. Division St. Salisbury</u> DATE SIGNED <u>9/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>9-10-55</u>		<u>Bethel Cemetery</u>		<u>Ocean View, Del.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept. 9, 1955</u>		<u>Mary H. Holloway</u>		<u>Wm Howard Wells</u>		<u>Pittsville</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 9

RECEIVED

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly shall be detached for use as a burial transit permit.

VII AISC 1-55 11M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9165

CERTIFICATE OF DEATH

09178

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		1 Day		TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital				STREET ADDRESS (If rural give location) 713 Roger St.,			
3. NAME OF DECEASED (First) (Middle) (Last) ROBERT McLEAN COLLINS				4. DATE OF DEATH (Month) (Day) (Year) 9 17 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Dec 17, 1989		9. AGE last birthday 65 yrs.		10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. House Painter		10b. KIND OF BUSINESS OR INDUSTRY Own Self		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Collins				14. MOTHER'S MAIDEN NAME Anda Lewis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-2141		17. INFORMANT & ADDRESS Mrs Franklin Ennis, Same			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
122.1 IMMEDIATE CAUSE (A) <i>Acute Cardiac decompensation</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Chronic myocarditis arteriosclerotic</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 4, 1954 to Sept. 17, 1955 that I last saw the deceased alive on Sept. 17, 1955 and that death occurred at 3:45 A.M. from the causes and on the date stated above. SIGNATURE <i>Frederic A. Lowrey</i> M.D. 116 E. Main St., Salisbury, Md. 9/19/55 ADDRESS (Street, city, town, state) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 9/19/55		NAME OF CEMETERY OR CREMATORY St. John's Cemetery		LOCATION (City, town, or county) (State) Powellville, Maryland	
24. REC'D BY REGISTRAR DATE Sept. 20, 1955		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Normant. Baker</i> ADDRESS The Hill & Johnson Co. Salisbury, Md.			

0188240 P. S.

SEP



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9207

CERTIFICATE OF DEATH

Item 9 Film 0186 9-20-55 et

Reg. Dist. No. 335

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>SHARPTOWN</u>		<u>78 YRS</u>		TOWN <u>SHARPTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WATER ST</u>				STREET ADDRESS (If rural give location) <u>WATER ST</u>			
3. NAME OF DECEASED (Type or Print) <u>JOSEPH PHILLIPS COOPER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 6 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT 25, 1876</u>	9. AGE last birthday <u>78 YRS.</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL J. COOPER</u>				14. MOTHER'S MAIDEN NAME <u>RACHEL ANN PHILLIPS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-32-7592</u>		17. INFORMANT & ADDRESS <u>MRS MARGARET COOPER</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
401 IMMEDIATE CAUSE (A) <u>Cerebral Embolism</u>						2. When	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension - Coronary Thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 31, 1955</u> to <u>Sept 6, 1955</u> , that I last saw the deceased alive on <u>Sept 6, 1955</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Honor Elliott</u>				ADDRESS (Street, city, town, state) <u>M.D. Laurel - Del</u>		DATE SIGNED <u>9-9-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>SEPT 9-55</u>		NAME OF CEMETERY OR CREMATORY <u>FIREMENS</u>		LOCATION (City, town, or county) <u>SHARPTOWN MD</u>	
24. REC'D BY REGISTRAR <u>Mary Cowen</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul J. Smith</u>		ADDRESS	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be examined within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

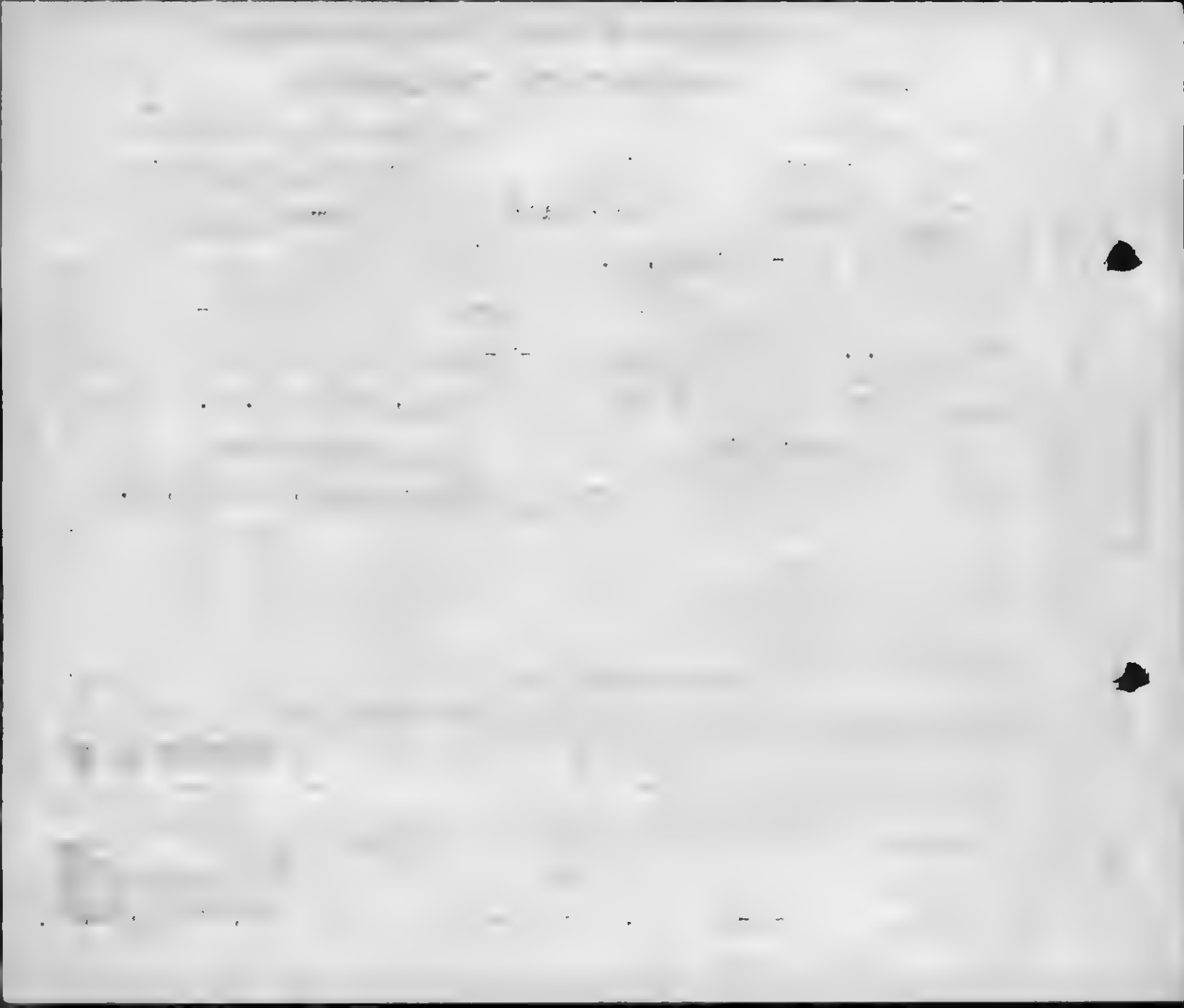
9208

CERTIFICATE OF DEATH

09180

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Fruitland		Most of life		TOWN Fruitland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - Fruitland, Md.				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) Cecile Fountain Cottman				4. DATE OF DEATH (Month) (Day) (Year) 9 - 6 - 19 55			
5. SEX Female	6. COLOR OR RACE A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 5-25-1892		9. AGE last birthday 63 yrs.		IF UNDER 1 YEAR Months Days 3 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Pelks Road, Somerset Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Paige				14. MOTHER'S MAIDEN NAME Mamie Langford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Richard Cottman, Fruitland, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
260X IMMEDIATE CAUSE (A) Diabetic Acidosis						Diabetic	
ANTECEDENT CAUSE(S) DUE TO (B) Diabetic Mellitus						Diabetic Mellitus	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from to that I last saw the deceased alive on and that death occurred at M. from the causes and on the date stated above.							
SIGNATURE <i>J. H. Halloway</i>				ADDRESS (Street, city, town, state) M.D. 6524 W. St. Salisbury Md 21804		DATE SIGNED 9/25/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9-10-55		NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		LOCATION (City, town, or county) (State) Fruitland, Wicomico Co. Md.	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE <i>Mary H. Halloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Mary A. Stewart</i> ADDRESS 324 E Church St. Salisbury Maryland			



09181

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 1/2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Ranier</u>		<u>16-16-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>4517 - 32nd Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE	
(First) <u>Olive</u> (Middle) <u>Almonia</u> (Last) <u>Croson</u>				(Month) <u>Sept.</u> (Day) <u>16</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/25/1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>68</u>	IF UNDER 24 HRS Days <u>68</u>	Hours <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Sprakes</u>				14. MOTHER'S MAIDEN NAME <u>Lura Sprakes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Hypertensive arteriosclerotic cardiovascular disease</u>						<u>3 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis - general</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Parkinson's Disease</u>						<u>6 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 28</u> , 19 <u>52</u> , to <u>Sept. 16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 16</u> , 19 <u>55</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. V. Juerman</u>				V. Juerman, M.D.;		DATE SIGNED <u>9/16/55</u>	
				ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital, Salisbury, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>9/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		LOCATION (City, town, or county) <u>Waxpool Va</u>	
24. REC'D BY REGISTRAR <u>Sept 19, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary W. Galloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F. Boscha</u>		ADDRESS <u>Sons of Hyattsville Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

0167

CERTIFICATE OF DEATH

09182

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY OR TOWN <u>Salisbury</u>		CITY OR TOWN <u>Salisbury</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN		CITY OR TOWN	
12 TOWN <u>Salisbury</u>		Most of life		STREET ADDRESS		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		4. DATE OF DEATH	
First <u>Norman</u> Middle <u>Curtis</u> Last <u>Curtis</u>		First <u>Norman</u> Middle <u>Curtis</u> Last <u>Curtis</u>		Month <u>Sept.</u> Day <u>18</u> Year <u>1955</u>		Month <u>Sept.</u> Day <u>18</u> Year <u>1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	IF UNDER 24 HRS.
Male	AA	Married	7-2-1917	58 yrs.	Months <u>2</u> Days <u>16</u>	Hours <u></u> Min. <u></u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Printer		Conley's Cleaner		Hebron, Wicomico Co. Md.		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Edward Taylor				Edith Curtis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Yes		220-10-9846		Mrs. Maggie Curtis 403 E. Rose St. Salisbury, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
542X IMMEDIATE CAUSE (A)				Renal Failure Uremia			
ANTECEDENT CAUSE(S) DUE TO				Gluconolipidosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Hypertension			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		20. AUTOPSY?	
21		N		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		21c. WHERE DID INJURY OCCUR? (City or town)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		21f. HOW DID INJURY OCCUR?		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		21f. HOW DID INJURY OCCUR?		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug. 24</u> , 19 <u>55</u> , to <u>Sept. 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 17</u> , 19 <u>55</u> , and that death occurred at <u>3:22 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>D. Herbert Sewell M.D.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>			
DATE SIGNED <u>9/20/55</u>				DATE SIGNED <u>9/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		9-22-55		Green Acres Mem. Park		Salisbury, Wicomico Co. Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 21, 1955		Mary H. Holloway		Mary A. Stewart		224 E. Church St. Salisbury, Maryland.	

U. S. V. S.

SEP 21 1975

100

9168

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>				TOWN <u>Charm</u>		19X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Andrew Dashiell</u>				OF DEATH: <u>9</u> <u>18</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widower</u>	8. DATE OF BIRTH: <u>Sept 18 1876</u>	9. AGE last birthday: <u>79</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, if not dead)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Waterman</u>						<u>Md.</u>	
13. FATHER'S NAME: <u>Sidney Dashiell</u>				14. MOTHER'S MAIDEN NAME: <u>Virginia Winsor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>						<u>Harold White Phoenician Anne Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Coronary Heart Failure</u>							
ANTECEDENT CAUSE (B) <u>Cerebral Hemorrhage</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension + Atherosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/7/55</u> , 19 <u>55</u> , to <u>9/18/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/18/55</u> , 19 <u>55</u> , and that death occurred at <u>12:05</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>Harold White</u>				ADDRESS <u>1136 Church St</u>		DATE SIGNED <u>9/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/20/55</u>		<u>Oriskany Cemetery</u>		<u>Oriskany Md.</u>	
DATE REQ'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>9-17-55</u>		<u>Mary W. Holloman</u>		<u>Phoenician Anne Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STANLEY A. M.

SEP 21 1995

100-100000

9169

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		8 days		TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital				STREET ADDRESS (if rural give location) 515 Collins Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Garfield		(Middle) Henry		(Last) Dashiell		(Month) Sept. (Day) 9 (Year) 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
Male	Colored	Married	6/10/1894	61 yrs.	Months 2	Days 29	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Brickyard		White Haven, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Dashiell				Henrietta Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Yes		WW-1		Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
16. X IMMEDIATE CAUSE (A) Squamous cell carcinoma of left maxillary				INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
ANTECEDENT CAUSE(S) DUE TO antrum with metastasis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
01							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 1 , 19 55 , to Sept. 9 , 19 55 , that I last saw the deceased alive on Sept. 8 , 19 55 , and that death occurred at 12:20 A.M. , from the causes and on the date stated above.							
SIGNATURE		R. J. Gore, M.D.		Deer's Head State Hospital		DATE SIGNED	
[Signature]		M.D.		Salisbury, Maryland		9/9/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		9-13-55		Green Acres Memorial Park		Salisbury, Wicomico Co. Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		[Signature]		[Signature]		324 E Church St Salisbury, Md.	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1000

1000

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09185

CERTIFICATE OF DEATH

Reg. Dist. No. 332

9170

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Marion Station</u>		19x-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
FANNIE DAVIS				DEATH Sept. 24 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W		Sept 4, 1863	92 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				At Home		Marion Station, Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Samuel Pull				Catherine Gunby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						Mrs Eva Mills, Marion Station, Md	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				Interval between onset and death			
ANTECEDENT CAUSE(S) DUE TO				6 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				Arteriosclerosis C.V.D.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
C							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from 9:00, 1955, to 9:24, 1955, that I last saw the deceased alive on 9:24, 1955, and that death occurred at 10:15 P.M. from the causes and on the date stated above.							
SIGNATURE <u>H. Brule</u>				ADDRESS (Street, city, town, state) DATE SIGNED 9-25-55			
M.D. <u>226 N. Duane St</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		9-27-55		St Pauls Cemetery		Marion Station, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 9-26-55		Mary W. Holloman		Bradshaw & Sons, Crisfield, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS AISC 1-55 101

RECEIVED

SEP

1961

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09186

9209

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Gesterville</u>		<u>Lifetime</u>		OR TOWN <u>Gesterville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>NETTIE</u> (Middle) (Last) <u>DAVIS</u>				(Month) <u>Sept.</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>May 16, 1877</u>	<u>78</u> yrs.	<u>4</u> Months <u>18</u> Days	<u>18</u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Gesterville, Md.</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Isaac Roberts</u>				<u>Julia Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		INFORMANT & ADDRESS			
<u>no</u>		<u>—</u>		<u>Harry Davis - Gesterville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				10. MEDICAL CERTIFICATION			
4x20.0 IMMEDIATE CAUSE (A)				<u>Acute Cardiac Failure</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				<u>Generalized Arteriosclerosis</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>1 hour</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 21</u> , 19 <u>47</u> , to <u>Sept 26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 26</u> , 19 <u>55</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Richard H. Saunders, M.D.</u>				<u>Northcote, Md.</u>		<u>26 Sept 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)			
<u>Burial</u>	<u>9/28/55</u>	<u>Oak Grove Cemetery</u>		<u>Gesterville, Md.</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
<u>Sept 30, 1955</u>	<u>Mary J. Hollaway</u>	<u>C. D. Mesick, Director, Md.</u>					

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SEP 30 1955

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9171

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Salisbury</u>				TOWN <u>Delmar</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General</u>				STREET ADDRESS (If rural give location) <u>Rt # 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Elmer</u> <u>Downs</u>				DATE OF DEATH: <u>9</u> <u>18</u> <u>1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>M</u>		<u>W</u>		<u>Married</u>		<u>7-15-09</u>	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>46</u> yrs		<u>LABORER</u>		<u>DELAWARE</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>UNKNOWN</u>				<u>MANNIE DOWNS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>4 NO</u>							
17. INFORMANT & ADDRESS:							
<u>Rhyspa Downes, Laurel, Delaware</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
581.0 IMMEDIATE CAUSE (A) DUE TO							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(C) <u>PORTAL CIRRHOSIS of LIVER</u>						<u>1-2 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>INANITION (nutritional failure)</u>						<u>2-3 months</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>5</u> , 19 <u>54</u> , to death, 19 <u>55</u> , that I last saw the deceased alive on <u>9/18</u> , 19 <u>55</u> , and that death occurred at <u>8:16</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Ernest M. Harmon</u>				ADDRESS <u>Delmar, Del</u>		DATE SIGNED <u>9/20/55</u>	
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>9/21/55</u>		<u>EPWORTH Church Cen</u>		<u>near Laurel, Delaware</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>9-21-55</u>		<u>Mary W. Holloway</u>		<u>J. Harvey Williams</u>		<u>Seaford, Del.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JOHN A. S.

1880

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9172

CERTIFICATE OF DEATH

09188

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Southern</u>	
CITY (If outside corporate limits, write TOWN OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write TOWN OR and give nearest town)		19X-2	
TOWN <u>Salisbury</u>				STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>							
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
(Type or Print)							
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>		8. DATE OF BIRTH: <u>Mar. 13, 1883</u>	
9. AGE last birthday <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life. (If retired, specify): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>md.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>Will Marriener</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Rusey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT & ADDRESS: <u>Mrs. Gladys Ford, Princess Anne Md.</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE				3 yrs. 2.			
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Myocardial Insufficiency</u>							
DUE TO							
(B) <u>Coronary Artery Heart Disease</u>							
DUE TO							
(C) <u>Hypertension, Arterial</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Ischemia</u>				1 yr.			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/11</u> , 1955, to <u>9/24</u> , 1955, that I last saw the deceased alive on <u>9/21</u> , 1955 and that death occurred at <u>12:35</u> M, from the causes and on the date stated above.							
SIGNATURE <u>David J. Gilmore</u>				DATE SIGNED <u>Sept. 2, 1955</u>			
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 4, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St Andrews Cemetery</u>		LOCATION (City, town or county) (State) <u>Princess Anne md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-6-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>James Thurman</u>		ADDRESS <u>Princess Anne</u>	

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09189

CERTIFICATE OF DEATH

Reg. Dist. No. . . .

9173

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico				STATE Maryland COUNTY Baltimore City			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN Salisbury		3 yrs 5 months		TOWN 715 W. Fayette St., Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital				STREET ADDRESS (If rural give location) 715 W. Fayette Street			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Loyal Glenn				9 1 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White	Single	11/7/1876	78 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unknown		— —		Pennsylvania		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Glenn				Julia Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		None		Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral thrombosis						8 days	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis, general						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr. 2 , 19 52 , to Sept. 1 , 19 55 , that I last saw the deceased alive on Sept. 1 , 19 55 , and that death occurred at 9:05 P.M. from the causes and on the date stated above.							
SIGNATURE L.V. Maldve, M.D.				ADDRESS (Street, city, town, state) Deer's Head State Hospital Salisbury, Maryland			
DATE SIGNED 9/2/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		Sept. 6/1955		Crematorium Bldg		Balt. 4nd.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 8, 1955		Mary H. Holloway		Booker Pluech			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 2, F47-180 0-10-55 et

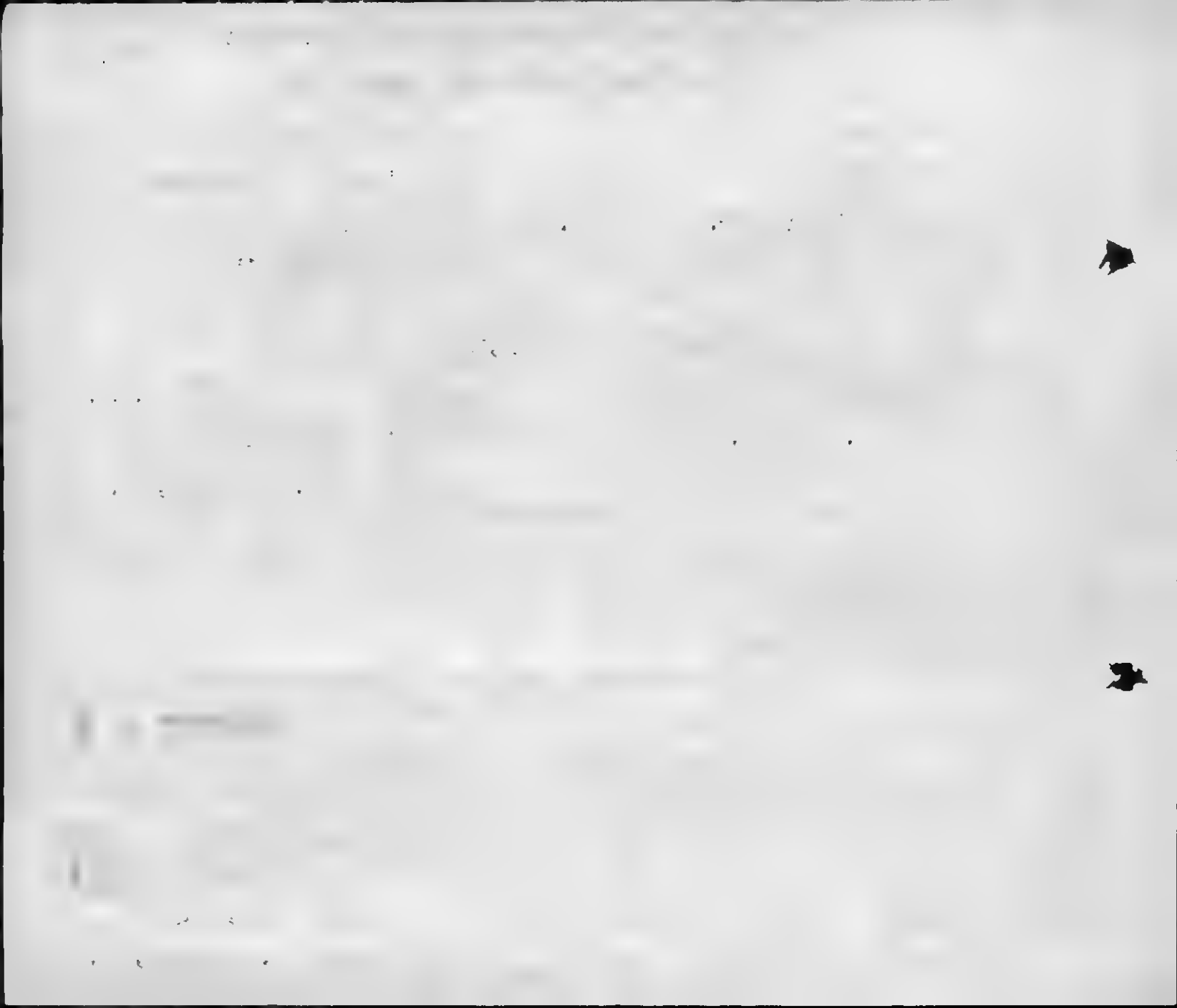
09190

0174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury 1 Hr.</u>		<u>1 Hr.</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>113 Walnut St.,</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>NANCY</u> <u>MURPHY</u> <u>GORDY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>9</u> <u>8</u> <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct, 31, 1881</u>		9. AGE last birthday <u>73</u> <u>74</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William S. Gordy Sr.,</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Brewington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes; no; unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Graham Gumby Jr. Salisbury, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Revolutional Hemorrhage</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u></u>							
(C) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/8</u> , 19 <u>55</u> , to <u>9/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/8</u> , 19 <u>55</u> , and that death occurred at <u>11:50</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Johnson</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>9/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>Sept 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary St. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thorman F. Baker</u>			
DATE				ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9175
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03491st.
No. 832

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE MD. COUNTY S.C.			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN Salisbury		2 Mos		TOWN Charleston			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital				STREET ADDRESS (If rural, give location) 50 1/2 Cannon St.			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print) Henry		Franklin Green		9-3-55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
M	O	Single	Dec. 18, 1933	21 yrs	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Freezing Plant		Poultry		Charleston, S.C.		U. S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Alexander Green				Elsie Small			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk-)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
Yes		248 50 3526		50 1/2 Cannon St Mr. Alexander Green Charleston, S.C.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Gunshot wound of left chest and abdomen--hemo-thorax							3 hours
DUE TO left and hemo-peritoneum.							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home.		21c. (City or town) (County) (State)			
Salisbury Wicomico Maryland		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 9 3 55 2A M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Shot during a quarrel.	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		M. D.		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DATE SIGNED			
Emile Ruge				9-6-55			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		9/8/55		Resurrection Cemetery		Charleston, S.C.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
9-6-55		Marylin Seymour		J.F. STEWART FUNERAL HOME		Salisbury, Md.	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

9178

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 10&21 Film G197 10-6-70

09192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>6 WEEKS</u>		TOWN <u>OCEAN CITY</u> <u>23X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Peninsula General Hospital</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Annie Pointer. Hall</u>				<u>Sept. 25 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>		<u>7 1883</u>	<u>71?</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>		<u>OWN HOME</u>		<u>BERLIN, MD R.F.D.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM ZULLEN</u>				<u>HETTIE POINTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>MR. HARRY HALL, SALISBURY, MD</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				(B) <u>Fractured left hip</u>			
ANTECEDENT CAUSE(S) (B)				<u>Lobular pneumonia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)				<u>Uremia</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<u>U</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
		<u>Home</u>		<u>Ocean City</u>		<u>MD.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<u>8-15-1955</u> M.				<u>Fall</u>			
22. I hereby certify that I attended the deceased from <u>8-15-55</u> , to <u>9-21-55</u> , that I last saw the deceased alive on <u>9-21-55</u> , and that death occurred at <u>2:20</u> A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>H. Brail</u>				<u>M.D. 226 N. Sussex St</u>			
DATE SIGNED				DATE SIGNED			
<u>9-21-55</u>				<u>9-21-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>9/27/55</u>		<u>ODD FELLOWS</u>		<u>BISHOPVILLE MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Sept. 28, 1955</u>		<u>Mary H. Holloway</u>		<u>Anna D. Burboze</u>		<u>Berlin MD</u>	

SEP 10 1964

SEP

09193

9210

CERTIFICATE OF DEATH

Reg. Dist. No. 33✓

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Eden		20 Yrs.		TOWN Eden			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eden				STREET ADDRESS (if rural give location) 1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
NINA ELIZABETH HALLOCK				9 24 1955			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
				Widowed		Jan 9, 1895	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday		11. BIRTHPLACE (State or foreign country)	
House Wife		Own Home		60 yrs.		N.Y.	
13. FATHER'S NAME Claude Barry				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME	
No				214-34-5007		Elizabeth Hardy	
15. INFORMANT & ADDRESS				17. INFORMANT & ADDRESS			
				116 Hobart Ave., 5 Mrs. Lela M. Bulford, Syracuse, N.Y.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				Cerebral Hemorrhage -			
ANTECEDENT CAUSE(S) DUE TO (B)				Malignant Hypertension			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White at work Not white at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 9, 1955, to Jan 24, 1955, that I last saw the deceased alive on Jan 22, 1955, and that death occurred at 1 A.M. from the causes and on the date stated above.							
SIGNATURE Lee L. Lawrence M.D.				ADDRESS (Street, city, town, state) Fruitland, Md.			
DATE SIGNED 9-25-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9/28/1955		Hudson Cemetery		Hudson, New York	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 28, 1955		Mary H. Holloway		The Hill & Johnson Co. Salisbury, Md.		Norman F. Baker	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

SEP 27 1952

9177

CERTIFICATE OF DEATH

Reg. Dist. No.

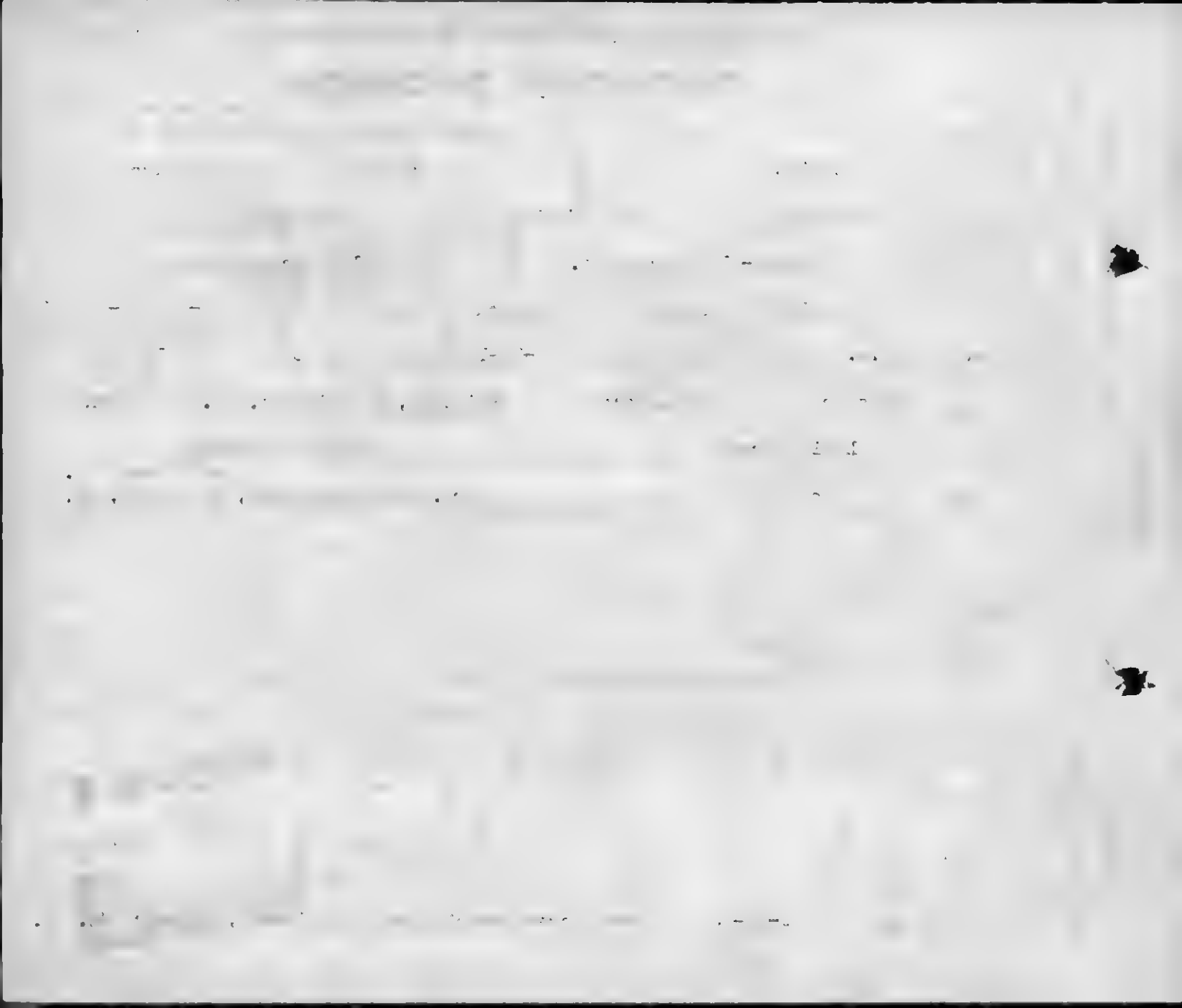
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		Most of life		TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
At home - 107 Second St.				107 Second Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Annie (Middle) Purnell (Last) Hauton				(Month) 9 (Day) 20 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	A.A.	Married	2-10-1890	65 yrs.	Months 7	Days 10	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Domestic		Housework		Salisbury, Wicomico Co., Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Levin Purnell				Sophie Birkhead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		No		107 Second St.			
				Mrs. Thelma Matthews, Salisbury, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				undetermined			
IMMEDIATE CAUSE (A) Cerebral Sclerosis							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 20, 1954 , to Sept 20, 1955 , that I last saw the deceased alive on 20 Sept 1955 , and that death occurred at 8:50 P M, from the causes and on the date stated above.							
SIGNATURE Adams, M.D.				ADDRESS (Street, city, town, state) 652 Wm. Salisbury Md.		DATE SIGNED 23 Sept 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9-25-55		Green Acres Memorial Park		Salisbury, Wicomico Co., Md.	
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 26, 1955		Mary J. Hollaway		Mary A. Stewart		324 E. Church St. Salisbury, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be obtained within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

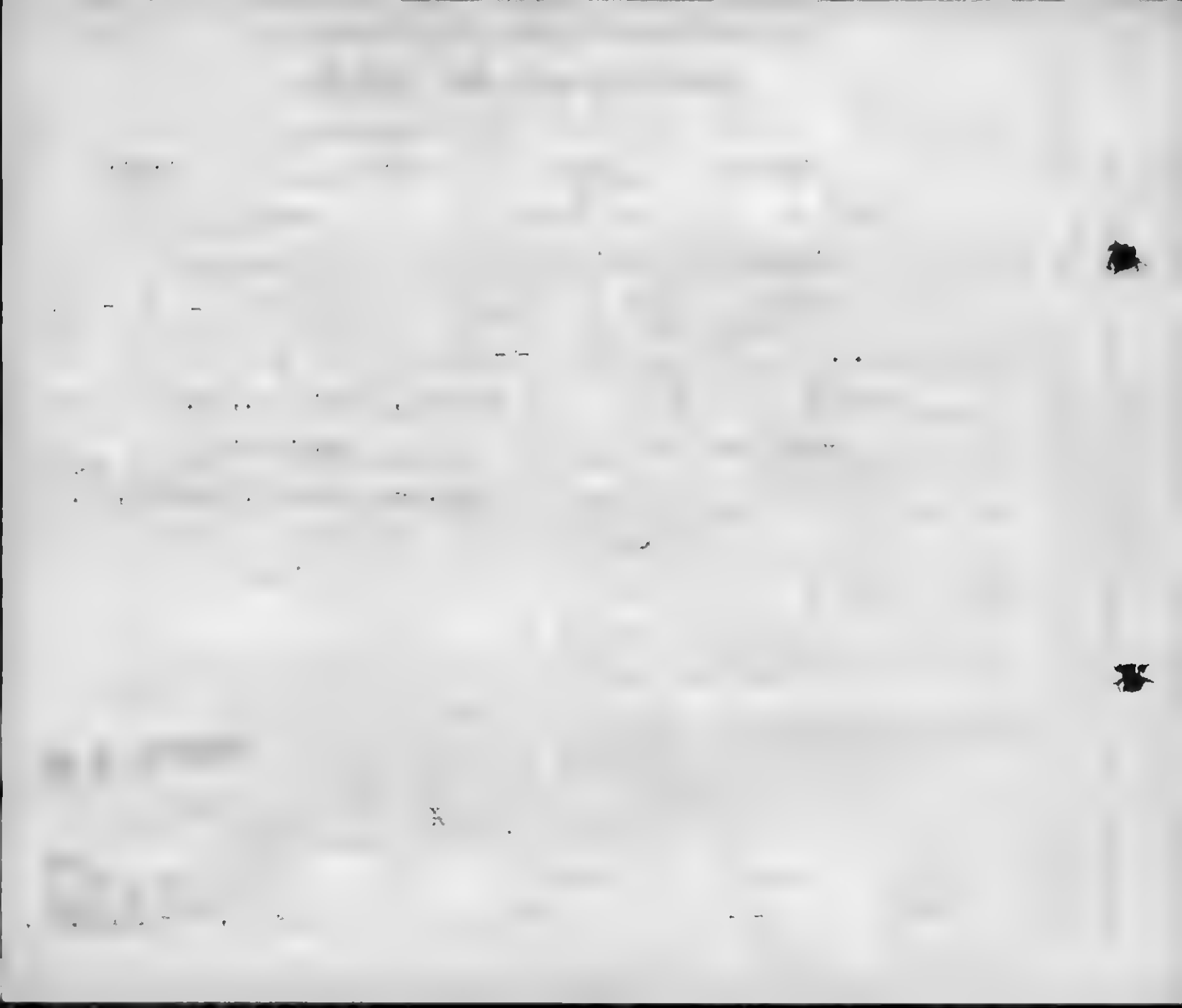
09195

9178

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury		LENGTH OF STAY (In this place) Most of life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital		STREET ADDRESS (If rural give location) 720 Lake Street					
3. NAME OF DECEASED (Type or Print) Annie Leah Hearn				4. DATE OF DEATH 9 - 30 - 19 55			
5. SEX Female		6. COLOR OR RACE A.A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow		8. DATE OF BIRTH 5-9-1871	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		9. AGE last birthday 84 yrs.		11. BIRTHPLACE (State or foreign country) Salisbury, Wicomico Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Henry West		14. MOTHER'S MAIDEN NAME Hettie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Goldie Twilley, Salisbury, Md.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.0 IMMEDIATE CAUSE (A) Arteriosclerotic heart disease							
ANTECEDENT CAUSE(S) DUE TO (B) Cerebrovascular accident							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Senility							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/25, 19 53 , to 9/22, 19 55 , that I last saw the deceased alive on 9/22, 19 55 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
SIGNATURE Andrew C. Mitchell M.D.				ADDRESS (Street, city, town, state) 320 E. Church St			
DATE Oct. 5, 1955				DATE SIGNED Mary A. Stewart, Salisbury, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-3-55		NAME OF CEMETERY OR CREMATORY Houston Cemetery		LOCATION (City, town, or county) (State) Salisbury, Wicomico Co., Md.	
24. REC'D BY REGISTRAR Mary T. Hallways		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart		ADDRESS 320 E. Church St	



1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 111M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9179

CERTIFICATE OF DEATH

09196

Reg. Dist. No. 327

Dr. Gramse

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Harford Co.			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Belair		12 X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 224 East Church St				STREET ADDRESS (If rural give location) # 1 William St			
3. NAME OF DECEASED (First) (Middle) (Last) JOSEPH CHANDLER HENDRICKSON				4. DATE OF DEATH (Month) (Day) (Year) SEPT 3 rd 19 55			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov. 30, 1898		9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR (Month) (Day) (Year) 9 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk -Auto Accessory Co.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William P. Hendrickson				14. MOTHER'S MAIDEN NAME Susan Chandler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Lucille L. Hendrickson (Wife) # 1 William St. Belair, Maryland			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
42 1. IMMEDIATE CAUSE (A) Cocaine Poisoning				INTERVAL BETWEEN ONSET AND DEATH Several			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/3 to 9/3, 1955, that I last saw the deceased alive on 9/3, 1955, and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Dr. Gramse</i>				ADDRESS (Street, city, town, state) S. Division St. Salisbury, Maryland		DATE SIGNED Sept 5 / 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 6, 1955		NAME OF CEMETERY OR CREMATORY Lower Brandywine Cemetery		LOCATION (City, town, or county) (State) Wilmington, Delaware	
24. REC'D BY REGISTRAR DATE Sept. 7, 1955		REGISTRAR'S SIGNATURE <i>Mary J. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			

U.S. AIR FORCE

EP

1954

9180

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bishop</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>R.R.</u>			
3. NAME OF DECEASED: (First) <u>Daisy</u> (Middle) <u>Mae</u> (Last) <u>Hudson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>September 17 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Feb 19, 1895</u>	
9. AGE last birthday: <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10a. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		9. AGE last birthday (If under 1 year) (If under 24 hrs.) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				11. BIRTHPLACE (State or foreign country): <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY: <u>USA</u>				13. FATHER'S NAME: <u>Joshua Morris</u>			
14. MOTHER'S MARDEN NAME: <u>Anna Mary Hickman</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>-</u>			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT & ADDRESS: <u>Edgar Hudson, Bishop, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>3 days</u>	
ANTECEDENT CAUSE (B) <u>Cerebral Atherosclerosis</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension, essential</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 15, 1955</u> to <u>Sept 17, 1955</u> , that I last saw the deceased alive on <u>Sept 16, 1955</u> , and that death occurred at <u>6:45A M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David Schum</u>		ADDRESS <u>Salisbury Md</u>		DATE SIGNED <u>Sept 17, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>9-19-55</u>		<u>9-19-55</u>		<u>I.O.O.F. Cemetery</u>		<u>Bishopville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-19-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Peter Whaley</u>		ADDRESS <u>Salisbury Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

108280 V. 2

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108280 V. 2

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

9181

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

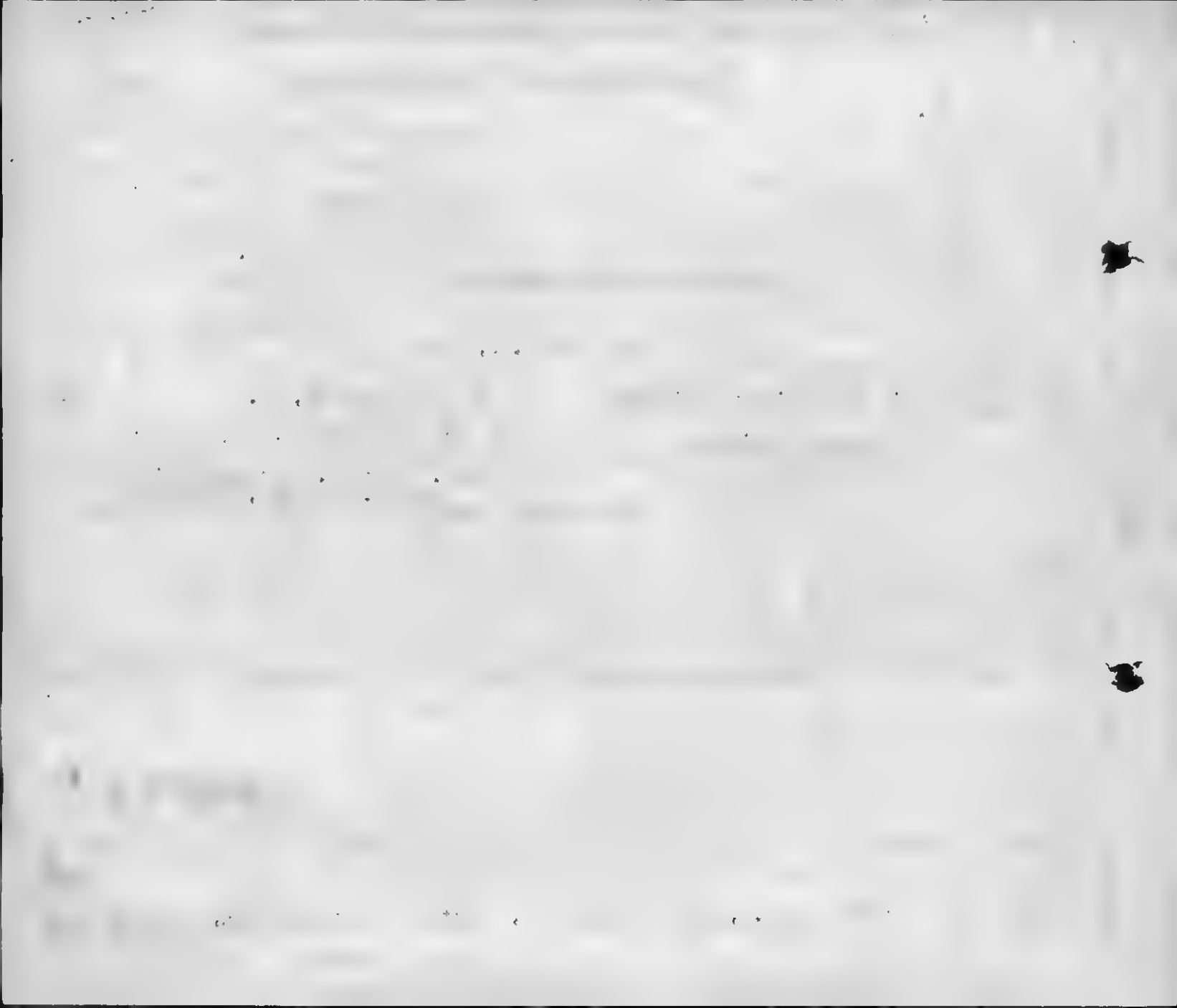
CERTIFICATE OF DEATH

09198

Dr. Ellis

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Salisbury</i>				TOWN <i>Delmar</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural give location) <i>203 East St.</i>			
3. NAME OF DECEASED (Type or Print) <i>CHARLES GRANVILLE HUNTINGTON</i> <i>Rev. Charles Huntington</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>September 6 1955</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 9, 1896</i>	9. AGE last birthday <i>58</i> yrs.	IF UNDER 1 YEAR Months <i>11</i> Days <i>27</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Minister & Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painting</i>		11. BIRTHPLACE (State or foreign country) <i>Near Parsonsburg, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Wesley Huntington</i>				14. MOTHER'S MAIDEN NAME <i>Miltelda (Matilda) Ella Collins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Yes</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mrs. Bessie M. Huntington (Wife) 203 East St. Delmar, Maryland</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Myocardial Infarct, acute</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic coronary thrombosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9-4</i> , 19 <i>55</i> , to <i>9-6</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>9-6</i> , 19 <i>55</i> , and that death occurred at <i>6:15 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>William B. Ellis Jr.</i> M.D.				ADDRESS (Street, city, town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>9-6-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Sept. 9, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Parsonsburg, Cemetery</i>		LOCATION (City, town, or county) (State) <i>Parsonsburg, Maryland</i>	
24. REC'D BY REGISTRAR <i>Sept. 8, 1955</i>		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY & COMPANY</i> ADDRESS <i>SALISBURY MARYLAND</i>			



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9185

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09199

CERTIFICATE OF DEATH

Reg. Dist. No. 332 ...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>DOA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Delmar</u>			
HOSPITAL OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>109 Lincoln Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Samuel Jarrell</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>September 27 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>January 6, 1906</u>	9. AGE last birthday: <u>49</u> yrs	10. UNDER 1 YEAR: Months Days	11. UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Wheeling, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>No data</u>				14. MOTHER'S MAIDEN NAME: <u>No data</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>Yes WW</u>				16. SOCIAL SECURITY NO. <u>221-09-4349</u>		17. INFORMANT & ADDRESS: <u>Rebecca Jarrell, Delmar, Delaware</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>						<u>2 hours</u>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Acute pulmonary edema</u>							
DUE TO							
(B) <u>Arteriosclerotic heart disease</u>							
DUE TO <u>with R. + L. ventricular failure</u>						<u>3 years?</u>	
(C) <u>Arteriosclerosis generalized</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 20, 1955</u> , to <u>Sept 27, 1955</u> , that I last saw the deceased alive on <u>Sept 25, 1955</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>Delmar Md.</u>		DATE SIGNED <u>9-29-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 30, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Delmar, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-30-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR ADDRESS <u>J.J. Frampton and Son, Federalsburg, Md.</u>			



Q. 1000000



9183

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place)		CITY OR TOWN <u>Millboro</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u> (Middle) (Last)				(Month) (Day) (Year)			
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>				7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)			
8. DATE OF BIRTH <u>September 29 1928</u>				9. AGE last birthday <u>26</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Forley Clayton Joseph</u>				14. MOTHER'S MAIDEN NAME <u>King Grace Philip</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT & ADDRESS <u>Father & Mother, Millboro Del.</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
762.5 IMMEDIATE CAUSE (A) <u>Atelectasis, Congenital</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/29/55</u> , 19 <u>55</u> , to <u>9/30/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/10/55</u> , 19 <u>55</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>			
DATE <u>10-3-55</u>				DATE SIGNED <u>10/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>10/1/55</u>		<u>Peninsula General Hospital, Salisbury, Md.</u>			
24. REG'D BY REGISTRAR				25. FUNERAL DIRECTOR'S SIGNATURE			
REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>				FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 12 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 55C 1-55 10M



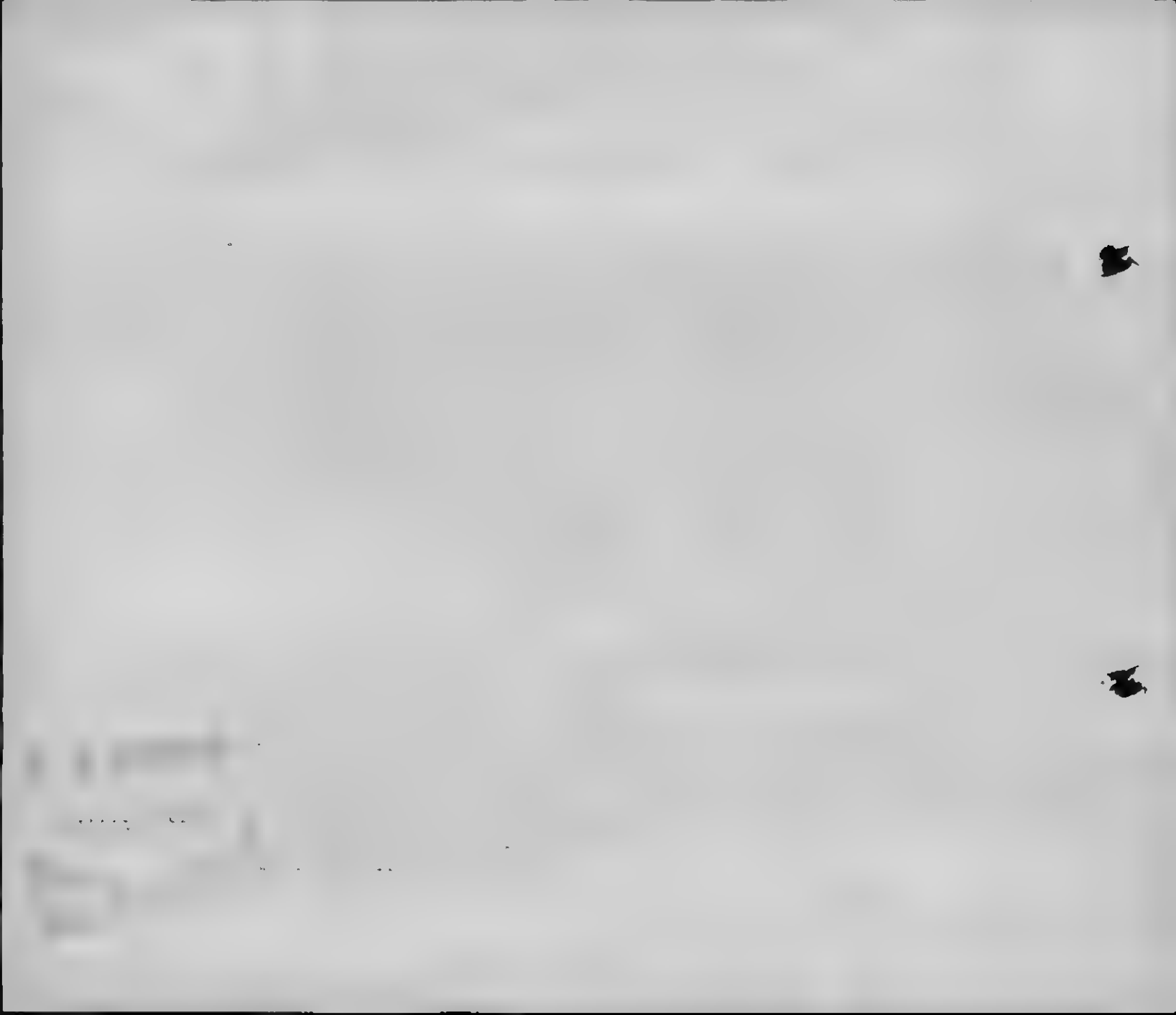
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9184
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09202
Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>6 WKS</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location) <u>823 West Main St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Eleanor Spencer Keyser</u>				4. DATE OF DEATH (Month) <u>9-</u> (Day) <u>10-</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>5-17-1866</u>	9. AGE last birthday: <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>THOMAS J. Willis</u>				14. MOTHER'S MAIDEN NAME: <u>MARY CHAPLIN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u>		16. SOCIAL SECURITY No.: <u>NONE</u>		17. INFORMANT & ADDRESS: <u>MRS. MIKE DISTAROOM, SAME</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>9040</u> Immediate cause (a)..... <u>Broncho-pneumonia</u> DUE TO Antecedent cause(s) (b)..... <u>Fractured right hip</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....						<u>3 days</u> <u>17 days</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7 25 55</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell at home.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>E. L. Rye</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>9-12-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>9/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>CHESTER CEMETERY</u>		LOCATION (City, town, or county) (State) <u>CHESTER TOWN, MD</u>	
DATE REC'D BY LOCAL REG. <u>9-12-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollomay</u>		24. FUNERAL DIRECTOR <u>Hill & Johnson Co.</u>		ADDRESS <u>Salisbury, MD</u> <u>Norman T. Baker</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. ... 10265 332

9185

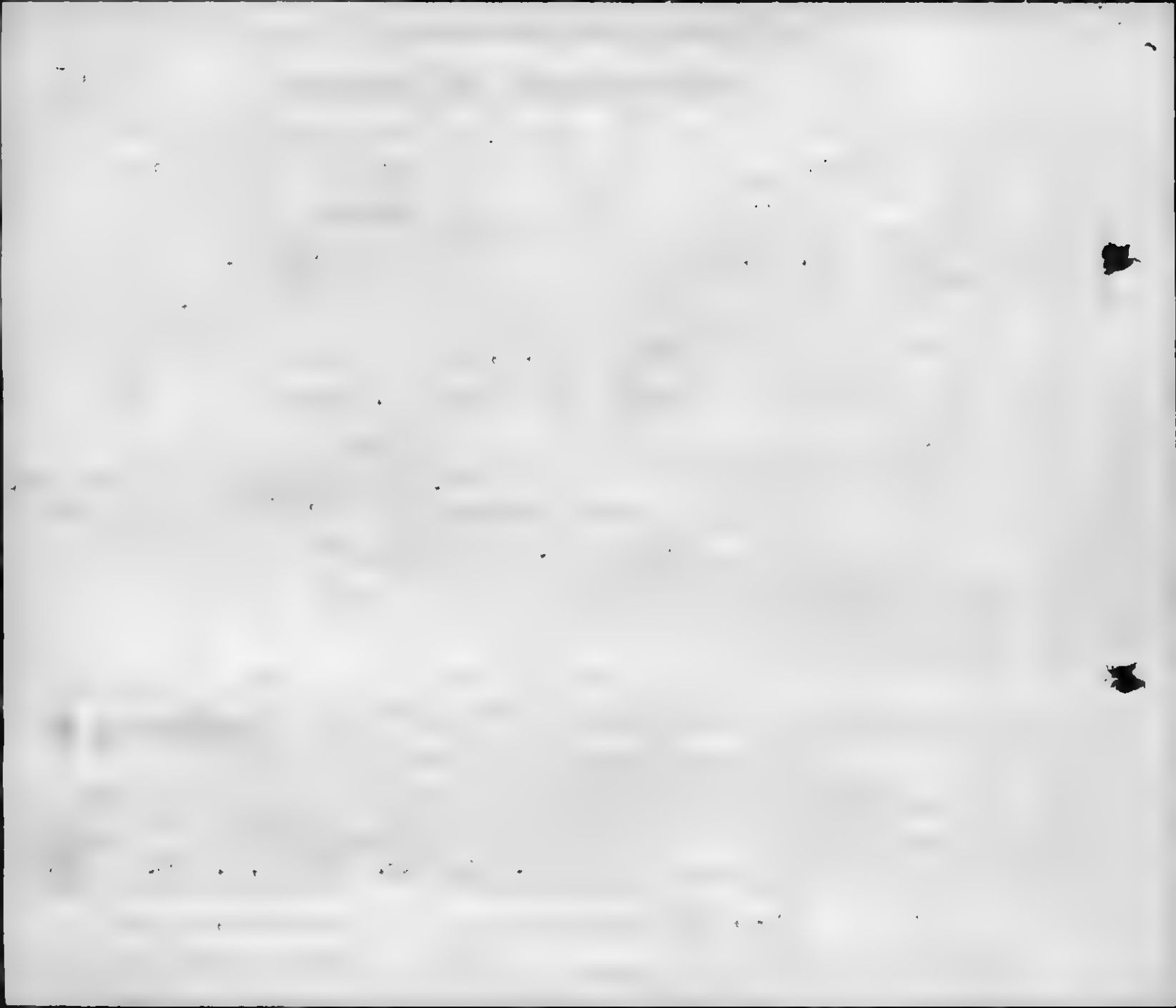
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 135 Truitt St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARY (Middle) ELIZABETH (Last) LECATES				(Month) Sept. (Day) 30 (Year) th 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	Jan. 6, 1885	70 yrs.	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House work		at Home		Sussex Co. Delaware		USA	
13. FATHER'S NAME John Davis				14. MOTHER'S MAIDEN NAME Kate (unk)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				Mrs. Vernon Ross (Daughter) 135 Truitt St. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 420.1				CORONARY OCCLUSION			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Sudden	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/29 , 19 55 , to 9/30 , 19 55 , that I last saw the deceased alive on 9/30 , 19 55 , and that death occurred at 10:40 from the causes and on the date stated above.							
SIGNATURE Fred R. Grammer				DATE SIGNED Oct. 1 1955			
ADDRESS (Street, city, town, state) S. Division St. Salisbury, Md.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 2, 1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR Oct. 11, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



0186

CERTIFICATE OF DEATH

09203

Reg. Dist. No.

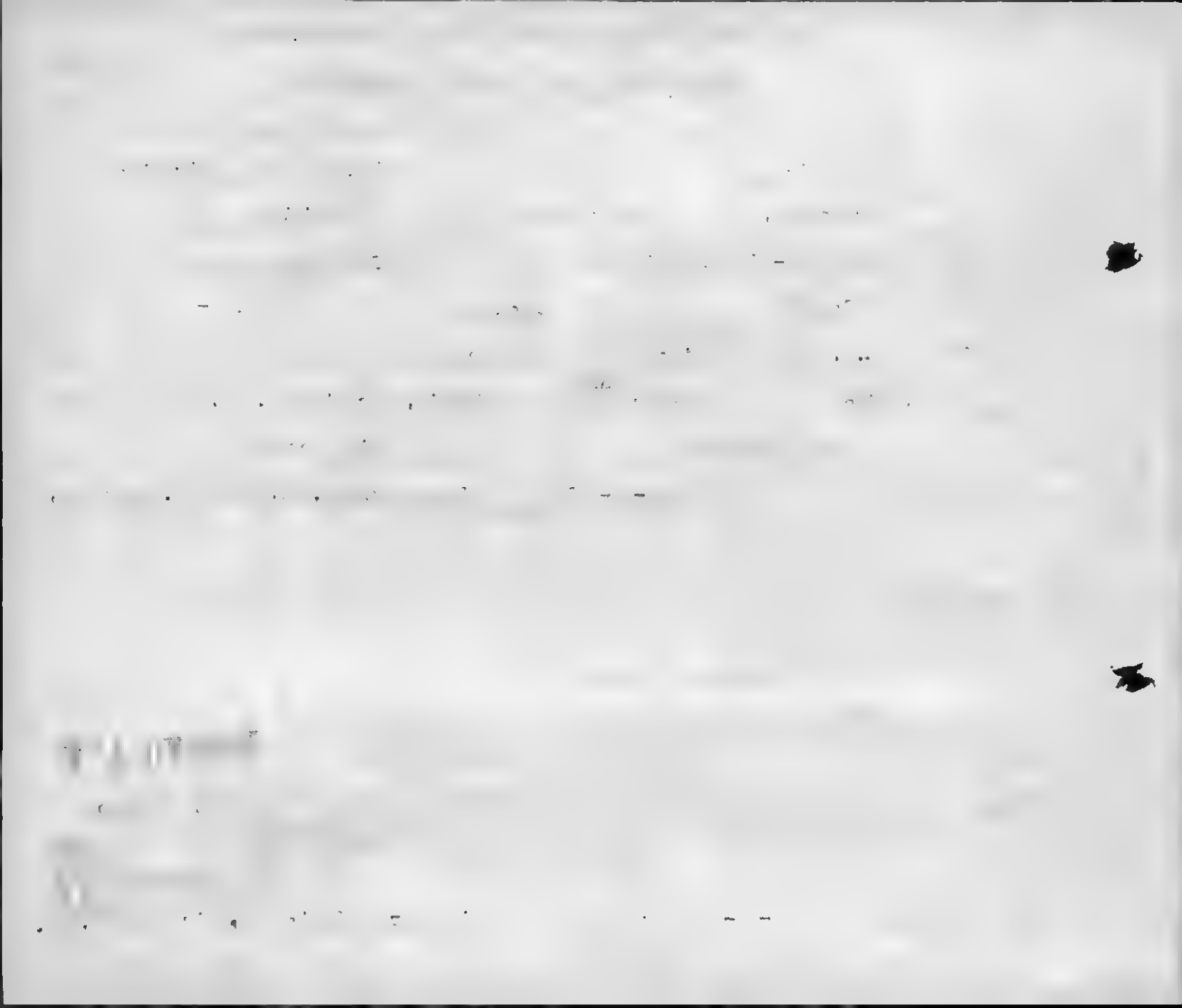
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury.		LENGTH OF STAY (in this place) Most of life		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - 615 Lake Street				STREET ADDRESS (If rural give location) 615 Lake Street			
3. NAME OF DECEASED (Type or Print) Samuel Leonard				4. DATE OF DEATH (Month) (Day) (Year) 9 - 11 19 55			
5. SEX Male		6. COLOR OR RACE A.A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH About 1894	
9. AGE last birthday About 61 yrs.		10. KIND OF BUSINESS OR INDUSTRY High Salisbury School		11. BIRTHPLACE (State or foreign country) Wetipquin, Wicomico Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Leonard				14. MOTHER'S MAIDEN NAME Emily Morris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 220-32-8613		17. INFORMANT & ADDRESS James Leonard, 615 Lake St. Salisbury, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Coronary Heart Disease</u>						5 days	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) _____ (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 7, 1955 to Sept 11, 1955 , that I last saw the deceased alive on Sept 11, 1955 , and that death occurred at 5:44 M. from the causes and on the date stated above. SIGNATURE M. D. 652:40 Kirk S/1 Salisbury, Md. 13 Sept 55 ADDRESS (Street, city, town, state) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9-14-55		NAME OF CEMETERY OR CREMATORY Green Acres Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Wicomico Co. Md.	
24. REC'D BY REGISTRAR Sept. 15, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart ADDRESS 324 E. Church St. Salisbury, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9187 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				09204 Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>in Hospital</u>		<u>7 days</u>		TOWN <u>Rural Pocomoke</u> - 18X2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
<u>Benicula General Hospital</u>			<u>✓</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
<u>Leno</u>			<u>Sept 26</u> 19 <u>55</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>June 8, 1875</u>	<u>80</u> yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work-life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Housewife</u>		<u>Home</u>		<u>Maryland</u>	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Joseph Dickerson</u>			<u>Henrietta Collins</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>none</u>		<u>none</u>		<u>Minnie Miller - Pocomoke City, Md.</u>	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<p>420.1 Immediate cause (a) <u>Died in hospital - acute coronary occlusion</u></p> <p>Antecedent cause(s) (b) <u>Following operation for fracture of</u></p> <p>giving rise to the above cause (c) <u>right hip - Had fall Sept 16, 55</u></p> <p>stating underlying cause last</p>					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Pocomoke R. FD Somerset Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Sept 16-55</u> A M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Had a fall in home</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Sept 29-55</u>			
<u>R. H. Johnson</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>10-11-55</u>		<u>Shall Hall - Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>9-29-55</u>		<u>Mary W. Holloman</u>		<u>Edgar A. Barker - Pocomoke</u>	
				ADDRESS	



CERTIFICATE OF DEATH

09205

Reg. Dist. No. 332

9188

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		TOWN <u>Salisbury</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Perinatal General Hospital 221 Broad St.</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>Lu F Fman</u>				(Month) (Day) (Year) <u>September 11 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>		<u>September 11 1935</u>	<u>20</u> yrs.	Months	Days	Hours Min. <u>1 55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Daisy Godwin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>none</u>		<u>Daisy Lu F Fman Broad St.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
762.5 IMMEDIATE CAUSE (A) <u>Placental birth - neonatal</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>death - instability and</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>other factors, 'hypertension'</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 11, 1955</u> to <u>Sept 11, 1955</u> , that I last saw the deceased alive on <u>11 Sept 1955</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Brundage</u>				ADDRESS (Street, city, town, state) <u>M.D. 96 N. Division St. Salisbury</u>		DATE SIGNED <u>9/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>cremation</u>		<u>9/12/55</u>		<u>Perinatal General Hospital</u>		<u>Salisbury Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>9-12-55</u>		<u>Mary W. Holloway</u>		<u>Perinatal General Hospital</u>			

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

SEP 1

1

INSTRUCTIONS

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VS AISC 1-55 10M

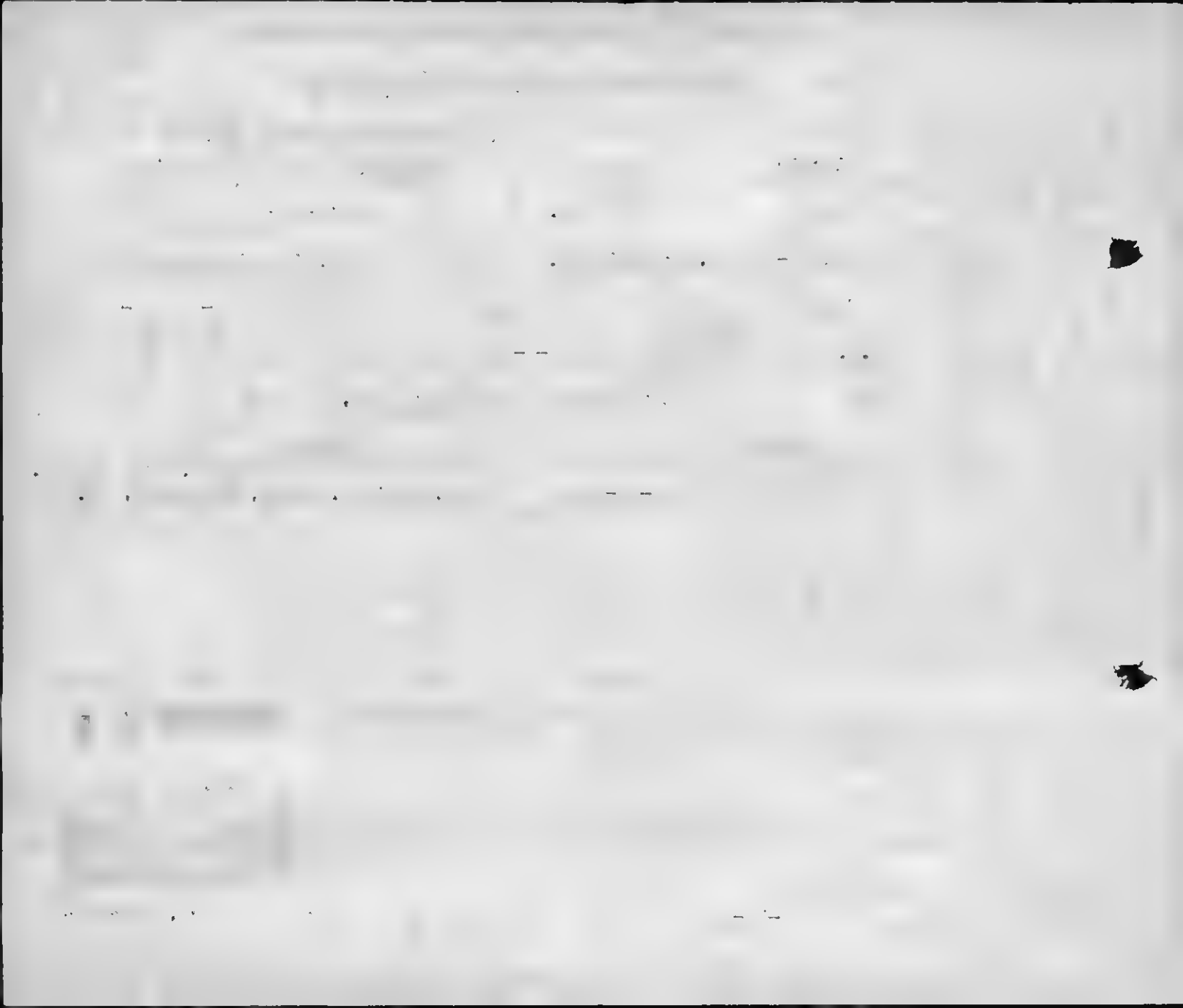
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09206

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		10 yrs.		TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
At home - 608 W. Isabella St.				608 W. Isabella Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Charles (Middle) Wilmore (Last) Mason				(Month) 9 (Day) 8 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	A.A.	Married	8-4-1908	47 yrs.	Months 1	Days 4	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Grocery Store		Salughter Neck, Delaware		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No (If Yes, give war or dates of service)		217-12-4688		608 W. Isabella St. Mrs. Essie S. Mason, Salisbury, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 442X Hypertensive Cardiovascular. Peril. Arterial Hypertension.						undetermined	
ANTECEDENT CAUSE(S) DUE TO (B) Malignant Hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 1, 1955 to Sept 7, 1955 , that I last saw the deceased alive on Sept 7, 1955 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
SIGNATURE E. J. Jernell		DATE THEREOF 9-11-55		NAME OF CEMETERY OR CREMATORY Slaughter Neck Cemetery		LOCATION (City, town, or county) Salisbury, Md (State) MD	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9-11-55		NAME OF CEMETERY OR CREMATORY Slaughter Neck Cemetery		LOCATION (City, town, or county) Salisbury, Md (State) MD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart		ADDRESS 324 E. Church St. Salisbury, Md.	
DATE							



1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

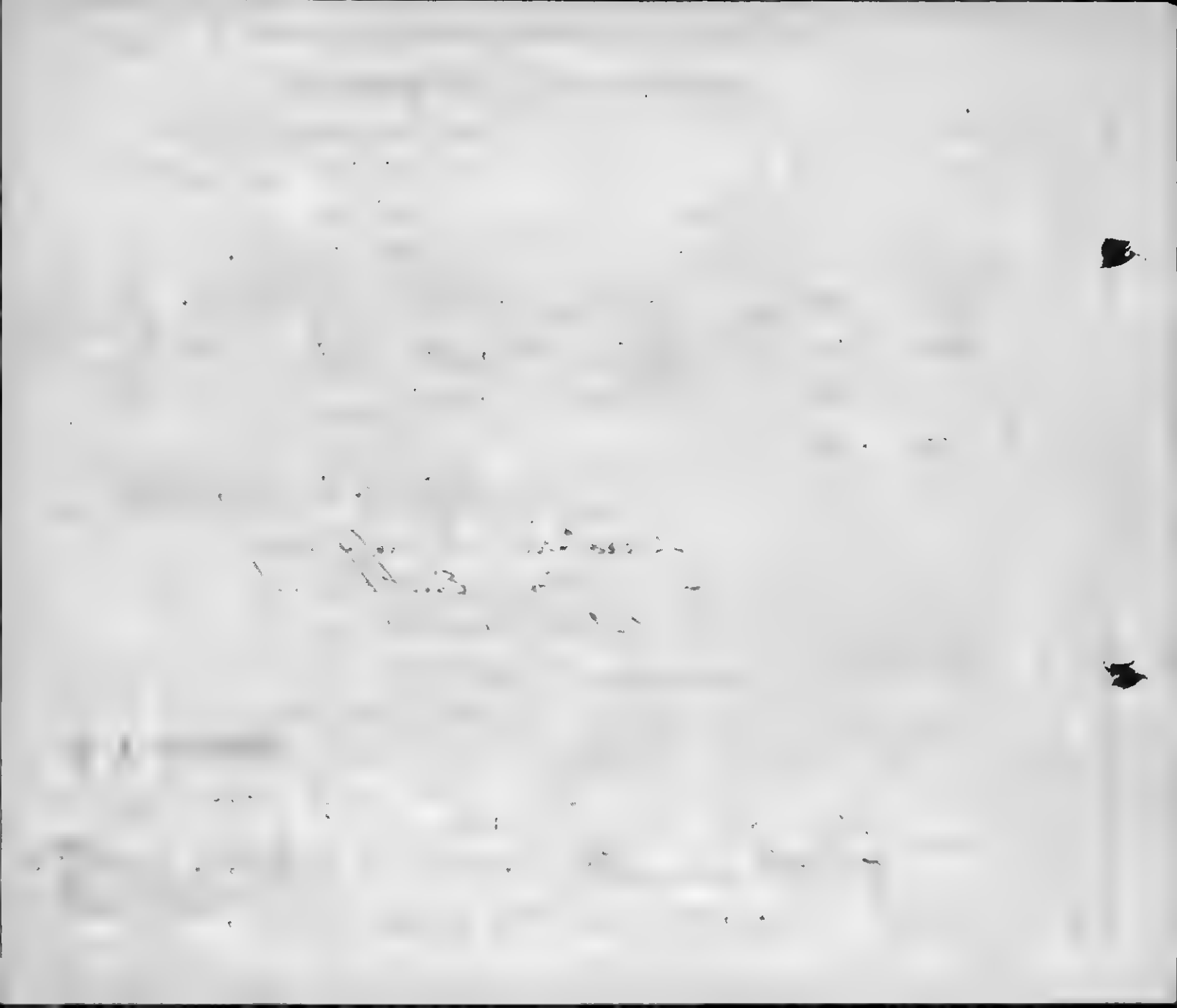
09207

Dr. Wm Smith

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		806 Cooper St		STREET ADDRESS		(If rural give location)	
				806 Cooper St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) SADIE (Middle) GERTRUDE (Last) MATTHEWS				(Month) Sept. (Day) 9th (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	Sept 29, 1883	71 yrs.	Months 11	Days 10	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Work		at home		Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Severn J. Evans				No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Mrs. Riley D. Green (Daughter) 806 Cooper St. Salisbury, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) Cardiac Insufficiency							
ANTECEDENT CAUSE(S) DUE TO (B) Diabetes, Embolism							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) arterio sclerosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1, 19 55 to 9-9 , 19 55 , that I last saw the deceased alive on 9/9 , 19 55 , and that death occurred at 1:30A M, from the causes and on the date stated above.							
SIGNATURE Wm Smith M.D.				ADDRESS (Street, city, town, state) N. Division St Salisbury, Md. Sept 10 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 12, 1955		Wicomico Memorial Park		Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE		Mary H. Holloway		HOLLOWAY & COMPANY		SALISBURY MARYLAND	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09209

9191

CERTIFICATE OF DEATH

Dr. Burton

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (In this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1032 East Main St				STREET ADDRESS (If rural give location) 1032 East Main St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) WALTER (Middle) JOSEPH (Last) MICKLETHWAITE				(Month) Sept. (Day) 2nd (Year) 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 4th 1874	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR Months 4 Days 28		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hatchery Laborer			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Walter Joseph Micklethwaite				14. MOTHER'S MAIDEN NAME Mary Ramsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. 		17. INFORMANT & ADDRESS Mrs. Beverly Micklethwaite, Salisbury, Md.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
4-2-1 IMMEDIATE CAUSE (A)				Myocardial infarction		1 day	
ANTECEDENT CAUSE(S) DUE TO (B)				Coronary artery atherosclerosis		Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Generalized atherosclerosis; hypertension		Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/23/1955 to 4/11/1955 , that I last saw the deceased alive on 4/9/1955 , and that death occurred at 4:00A.M. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) M.D. Maryland Ave. Salisbury, Maryland			
				DATE SIGNED Sept. 2 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 3, 1955		NAME OF CEMETERY OR CREMATORY Riverton Cemetery		LOCATION (City, town, or county) (State) Near Sharptown, Maryland	
24. REGD BY REGISTRAR Sept. 6, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND			

SEP



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INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 1011

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9211

CERTIFICATE OF DEATH

09208

Reg. Dist. No. 336

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico				STATE Maryland COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN Delmar		60 yrs		TOWN Delmar			
HOSPITAL OR INSTITUTION OR STREET ADDRESS State Street				STREET ADDRESS (If rural give location) State Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Annie (Middle) L. (Last) Nichols				(Month) Sept. (Day) 20 (Year) 19 55			
5. SEX	6. COLOR OR	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	8-23- 1875	80 yrs.	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
At Home		Home		Felton, Del.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Levin G. Beauchamp				Julia Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Howard Nichols, Delmar, Del.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) Acute Dilation of heart				30 min			
ANTECEDENT CAUSE(S) DUE TO (B) Chronic Myocarditis				5 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Arteriosclerosis				8 yrs			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 10, 1955 to Sept. 20, 1955 , that I last saw the deceased alive on Sept. 10, 1955 , and that death occurred at 4:4 A.M. from the causes and on the date stated above.							
SIGNATURE A. H. Lynch M.D.				ADDRESS (Street, city, town, state) Delmar, Del.		DATE SIGNED Sept. 22, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9-22-55		Mt. Olive Cemetery		Delmar, Del.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept 23, 1955		Harry E. Hudson		W. S. Marvel Co. Delmar, Del.			

8/28/2018

10:00 AM

10:00 AM

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly shall be detached for use as a burial transit permit.

VS AISC 1-55

9192

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

09210

Dr. Harry Mattox

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 800 Cooper St				STREET ADDRESS (If rural give location) 800 Cooper St.			
3. NAME OF DECEASED (First) (Middle) (Last) HERMAN JAMES OWENS				4. DATE OF DEATH (Month) (Day) (Year) Sept. 14 th 19 55			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 5, 1888		9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months 3 Days 9	IF UNDER 24 HRS. Hours 9 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (Victor Lynn Lines)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dames Quarter, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Owens				14. MOTHER'S MAIDEN NAME Priscilla White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Pearl M. Owens (Wife) 800 Cooper St. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) acute coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH immediate			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (B) DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/14, 1955, to 9/14, 1955, that I last saw the deceased alive on 9/14, 1955, and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
SIGNATURE Harry Mattox		M.D.		ADDRESS (Street, city, town, state) Camden Ave. Salisbury, Maryland		DATE SIGNED Sept. 16 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept 17, 1955		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			
DATE Sept. 19, 1955							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be examined within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A152 1-55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

09211

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE MARYLAND		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Eden		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS P.G. Hospt.				STREET ADDRESS (If rural give location) R.D. #2.			
3. NAME OF DECEASED (Type or Print) Annie Madora Phillips				4. DATE OF DEATH (Month) (Day) (Year) Sept. 27. 1955.			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH July 27, 1882.	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if House work)		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Wicomico County, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Rayall				14. MOTHER'S MAIDEN NAME Theodosia Chatham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Cecil E. Phillips (Son)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION R.D. # 2. Salisbury, Md.		INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE (A) Cardio vascular renal disease							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Salisbury Wicomico Maryland			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/12 , 19 55 , to 9/27 , 19 55 , that I last saw the deceased alive on 9/27 , 19 55 , and that death occurred at 11.30 A.M. , from the causes and on the date stated above.							
SIGNATURE Angela Husley				ADDRESS (Street, city, town, state) M.D. 116 E. Main St., Salisbury, Md. 10-1-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 1. 55.		NAME OF CEMETERY OR CREMATORY Trinity Cemetery		LOCATION (City, town, or county) (State) Near Allen, Maryland.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland.			
DATE Oct. 5, 1955							

For the various uses of this

Salisbury Woods

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09212

CERTIFICATE OF DEATH

Dr. Burton

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Riverside Nursing Home				STREET ADDRESS (If rural give location) 107 Center St			
3. NAME OF DECEASED (First) VENIE (Middle) ROSA (Last) PUSEY				4. DATE OF DEATH (Month) Sept. (Day) 9th (Year) 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Aug. 21, 1903	9. AGE last birthday 52 yrs.	IF UNDER 1 YEAR (Months) Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work, (Retired) at Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Laurel Delaware		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ebenezer White				14. MOTHER'S MAIDEN NAME Rosa Gordy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. J. Sidney White (Brother) 306 Monticello Ave. Salisbury, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
173X IMMEDIATE CAUSE (A) Generalized carcinomatosis						5 months	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of R. breast						2 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/8/55, 1955, to 9/7/55, 1955, that I last saw the deceased alive on 9/7/55, 1955, and that death occurred at 10:15 A.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city, town, state) Maryland Ave. Salisbury, Md.		DATE SIGNED Sept. 9 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 11, 1955		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary V. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			
DATE							



CERTIFICATE OF DEATH

Reg. Dist. No.

9185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY OR TOWN <u>Salisbury</u>		(If outside corporate limits, write RURAL and give nearest town)		CITY OR TOWN <u>Salisbury</u>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>637 S. Division St.</u>		LENGTH OF STAY (in this place) <u>20 yrs.</u>		STREET ADDRESS <u>637 S. Division St.</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>MARY Catherine RIGGIN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>9 20 19 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Mar. 14, 1878</u>	
9. AGE last birthday <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>John W. Riffin</u>			
14. MOTHER'S MAIDEN NAME <u>Martha Wimbrow</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT & ADDRESS <u>Mrs. Annie Godfrey - Same</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				5 days			
592X IMMEDIATE CAUSE (A) <u>Left cerebral thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arterio sclerosis & hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic glomerular nephritis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Uremia - Diabetes Mellitus</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/11</u> 19 <u>55</u> , to <u>9/20</u> 19 <u>55</u> , that I last saw the deceased alive on <u>9/20</u> 19 <u>55</u> , and that death occurred at <u>11:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>M.D. 211 Maryland Ave. Salisbury Md. 9/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/23/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>	
DATE <u>Sept. 26, 1955</u>							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

SEP

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 16 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09214

0196

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (In this place) Unk		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - First Street				STREET ADDRESS (If rural give location) First Street			
3. NAME OF DECEASED (Type or Print) Walter Roberts				4. DATE OF DEATH 9 - 10 - 19 55			
5. SEX Male		6. COLOR OR RACE A.A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Unk		8. DATE OF BIRTH 1913	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Red Carrier		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday 42 yrs.		11. BIRTHPLACE (State or foreign country) Demes Quarter, Maryland	
13. FATHER'S NAME Unk				14. MOTHER'S MAIDEN NAME Unk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 219-34-3483		17. INFORMANT & ADDRESS Salisbury, Md. Wicomico County Board of Welfare			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442X IMMEDIATE CAUSE (A) Cardiovascular Renal Disease				INTERVAL BETWEEN ONSET AND DEATH Indefinite			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) _____ (C) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 15 1955 , to Sept 19 1955 , that I last saw the deceased alive on Sept 10, 1955 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
SIGNATURE W. Purnell		DATE THEREOF 9-15-55		NAME OF CEMETERY OR CREMATORY Houston Cemetery		LOCATION (City, town, or county) (State) Salisbury, Wicomico Co. Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart		ADDRESS 324 E. Church St. Salisbury, Md.	

RECEIVED V. S.

SEP 1 1955

9212

09215

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
X TOWN <u>Bivalve</u>		<u>life</u>		TOWN <u>Bivalve</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Joyce Anne Smith</u>				<u>9 17 19 55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>O</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>infant</u>	8. DATE OF BIRTH: <u>8-9-55</u>	9. AGE last birthday: <u>1</u> yrs. <u>7</u> Months <u>7</u> Days	IF UNDER 1 YEAR		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		
13. FATHER'S NAME: <u>John Smith</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>John Smith, Bivalve, Md.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				Sudden			
<p>9240</p> <p>Immediate cause (a) <u>Mechanical asphyxiation</u> DUE TO</p> <p>Antecedent cause(s) (b) <u>—</u> DUE TO</p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>—</u></p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>9-17-55</u>				19b. MAJOR FINDING OF OPERATION: <u>—</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County, (State)			
<u>Bivalve</u>		<u>Wicomico</u>		<u>Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9-17-55 7A M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Sleeping on abdomen and smothered.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Roy</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-17-55</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>9/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Gesterville Cemetery</u>		LOCATION (City, town, or county) <u>Gesterville, Md.</u>	
DATE REC'D BY LOCAL REG. <u>9-21-55</u>		REGISTRAR'S SIGNATURE <u>Mary M. Holloway</u>		FUNERAL DIRECTOR <u>C. S. Wasson</u>		ADDRESS <u>Bivalve, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 10 days after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

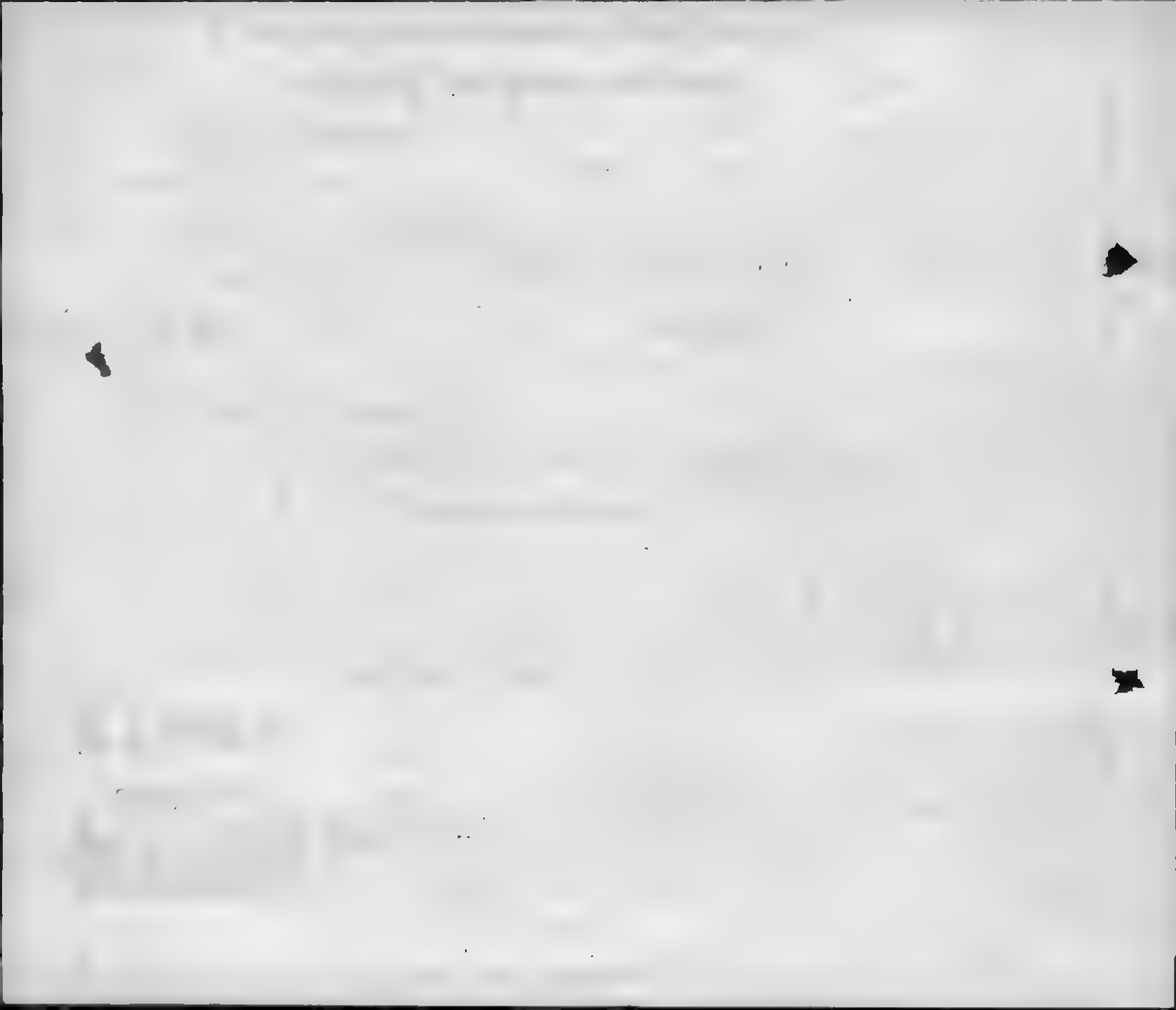
09216

9197

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY <u>Sussex</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>		LENGTH OF STAY (In this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		<u>41 X 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hosp.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Baby Boy Snyder</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>9 - 19 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>9-18-55</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min <u>12 40</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Theodore Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Violet Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION							
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
776X IMMEDIATE CAUSE (A) <u>Pneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ... 9/15, 1955, to ... 9/19, 1955, that I last saw the deceased alive on ... 9/19, 1955, and that death occurred at ... 5:30 P.M. from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>			
DATE SIGNED <u>9/19/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>9.20.55</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		LOCATION (City, town, or county) (State) <u>Wicomico Md</u>	
24. REC'D BY REGISTRAR DATE <u>9/26/55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS	



9198

CERTIFICATE OF DEATH

09217

Dr. Mattox

Reg. Dist. No.

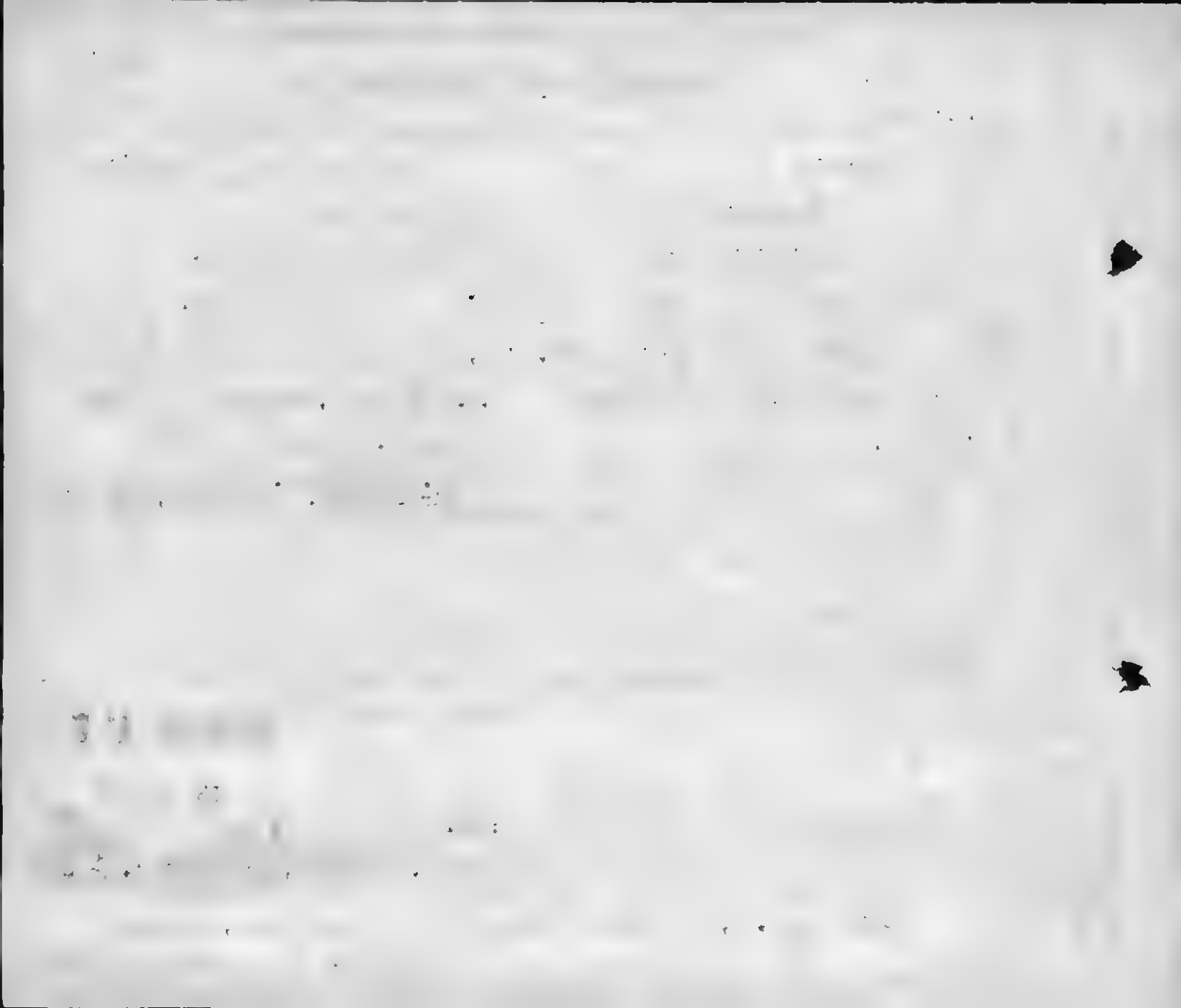
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 433 Virginia Ave				STREET ADDRESS (If rural give location) 433 Virginia Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ROBERT (Middle) NELSON (Last) TAYLOR				(Month) Sept. (Day) 6th (Year) 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, W-DOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 27th, 1909		9. AGE last birthday 46 yrs.	IF UNDER 1 YEAR (If UNDER 24 HRS. Months Days Hours Min.) 6 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Salesman		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) R.D.# Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William S. Taylor				14. MOTHER'S MAIDEN NAME Julia E. Townsend			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Catherine V. Taylor (Wife) 433 Virginia Ave. Salisbury, Maryland	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Acute coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
ANTECEDENT CAUSE(S) DUE TO (B) previous coronary sclerosis/infarction				5 months			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) coronary arteriosclerosis				3 years			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May , 19 55 , to Sept , 19 55 , that I last saw the deceased alive on Sept 6 , 19 55 , and that death occurred at 4:45A , from the causes and on the date stated above.							
SIGNATURE Harry Mattox				ADDRESS (Street, city, town, state) Camden Ave. Salisbury, Maryland Sept. 6 1955			
DATE Sept. 8, 1955				FUNDING DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 8, 1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNDING DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09218

CERTIFICATE OF DEATH

Reg. Dist. No.

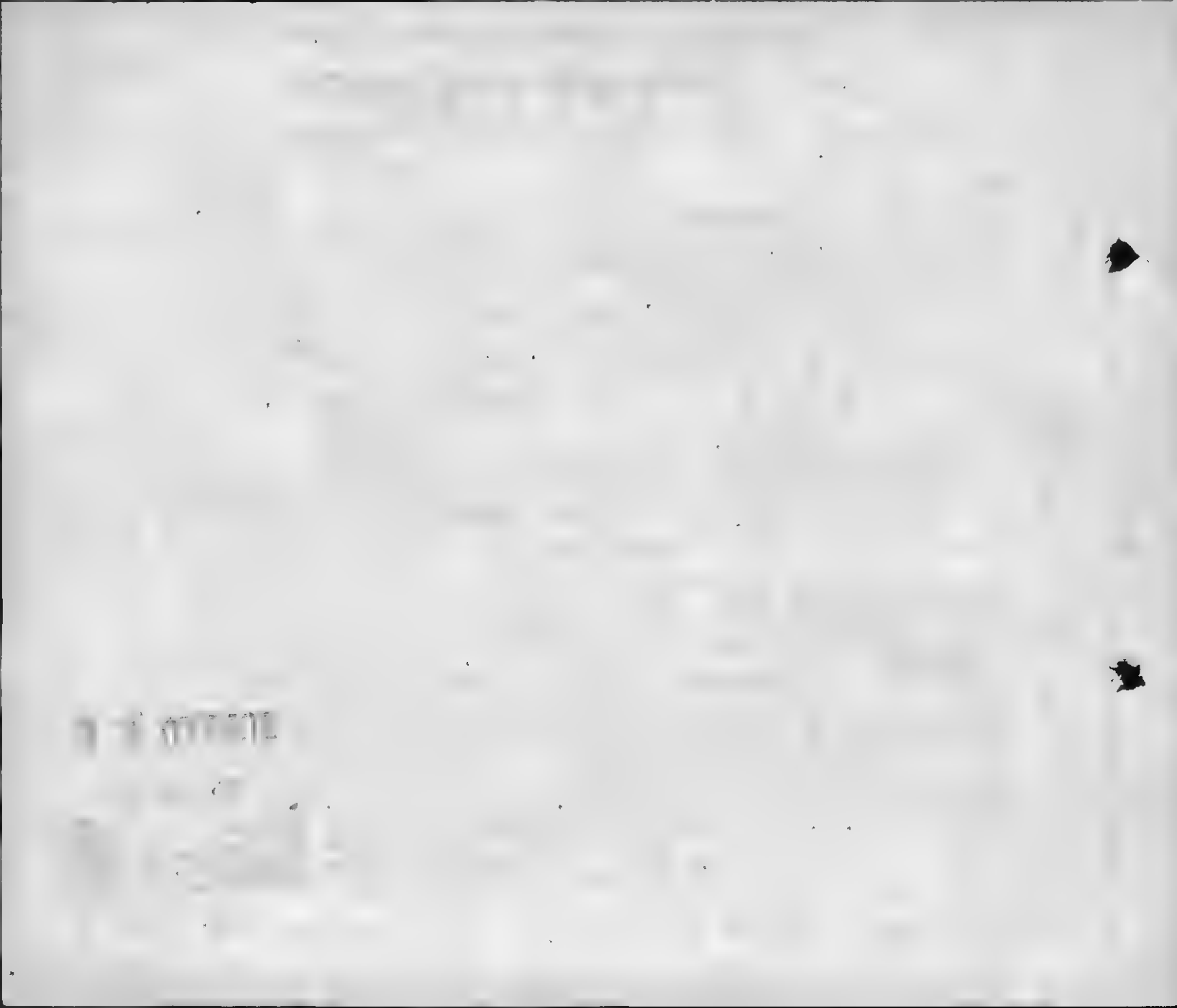
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury, Maryland		11 months		TOWN Cambridge, Maryland.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
William H. Warfield				Sept. 9, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Colored	separated	Dec. 24, 1898	56	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		unk		Cambridge, Maryland.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Warfield, Sr.				Henrietta Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		213 18 5351		Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Cerebral hemorrhage						1 1/2 hour	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						unknown	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 26, 1954 , to Sept. 9, 1955 , that I last saw the deceased alive on Sept. 9, 1955 , and that death occurred at 6:20p M., from the causes and on the date stated above							
SIGNATURE Dr. V. Guerman		ADDRESS (Street, city, town, state) M.D. Deer's Head Hospital, Salisbury, Md.		DATE SIGNED 9/9/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/13/1955		NAME OF CEMETERY OR CREMATORY Waugh Cemetery		LOCATION (City, town, or county) (State) Cambridge, Maryland	
24. REC'D BY REGISTRAR SIP		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE Herbert M. St. Clair		ADDRESS Cambridge, Md.	

VS A15C 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be furnished for use as a burial transit permit.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09219

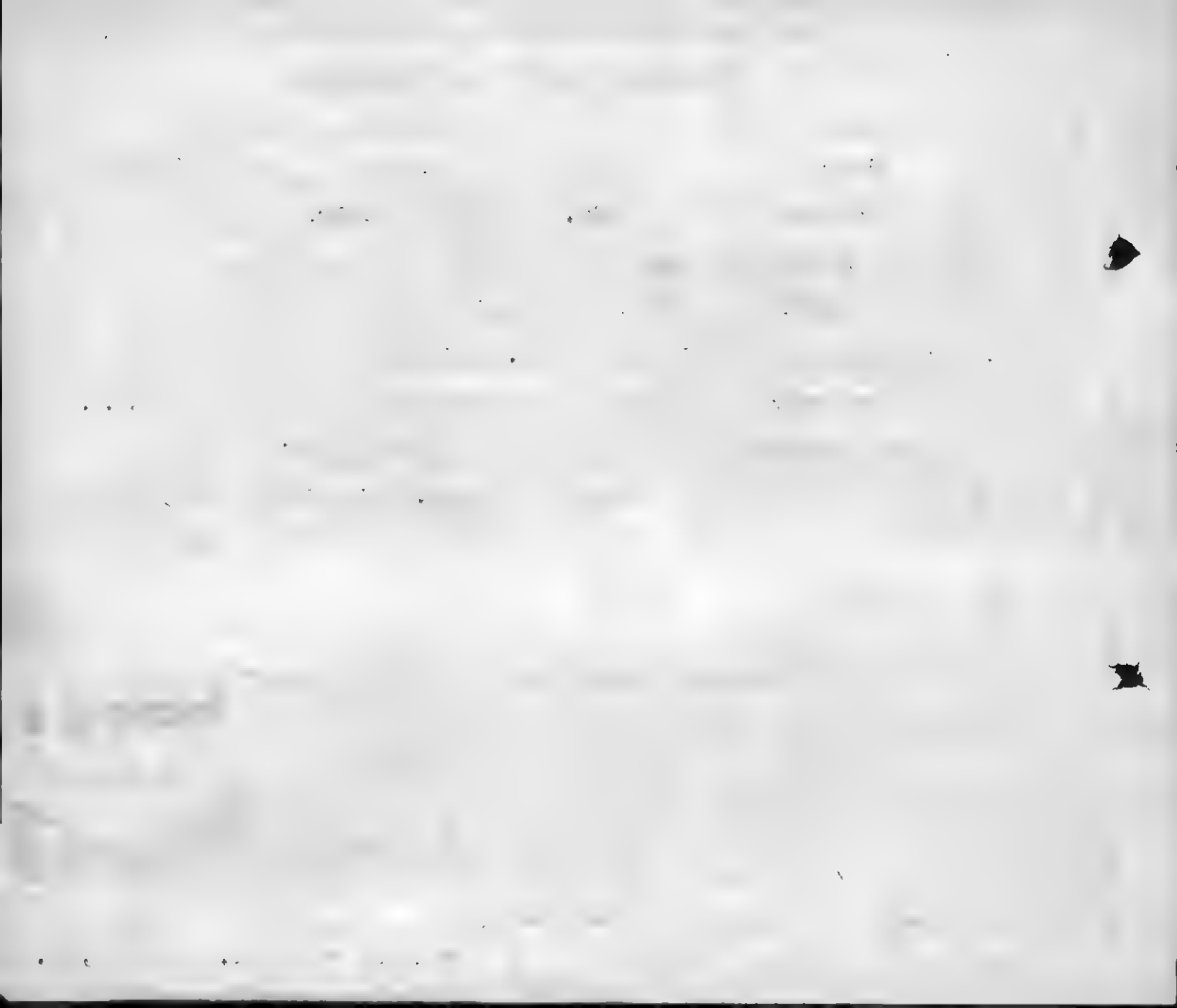
9200

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 8 Film 57 9-29-55 et.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place) 5 wks.		CITY (If outside corporate limits, write RURAL and give nearest town) Allen			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wilmer Nursing Home				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) RETTA (Middle) ESTHER (Last) WENDT				(Month) 9 (Day) 20 (Year) 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 22, 1886	9. AGE last birthday 66 yrs.	IF UNDER 1 YEAR Months 8		IF UNDER 24 HRS. Hours 20 Min. 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Huffington				14. MOTHER'S MAIDEN NAME Eliza Pollitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Mrs. Louise Elzey Allen, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) Arteriosclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Cerebro Vascular accident							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/13 , 19 55 , to 9/12 , 19 55 , that I last saw the deceased alive on 9/12 , 19 55 , and that death occurred at 2:11 M., from the causes and on the date stated above.							
SIGNATURE A. C. Mitchell				ADDRESS (Street, city, town, state) 211 Maryland Salisbury Ind 7/22/58			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/22/1955		NAME OF CEMETERY OR CREMATORY Allen Cemetery		LOCATION (City, town, or county) (State) Allen Maryland	
24. REG'D BY REGISTRAR Sept. 26, 1955 Mary D. Holloway				25. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, MD.			



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9211 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09220

CERTIFICATE OF DEATH

Reg. Dist. No. 832

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Ella S. Willett</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>September 27, 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, <u>DIVORCED</u> . (Specify):		8. DATE OF BIRTH: <u>Dec 8, 1906</u>	
9. AGE last birthday <u>48</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Accomac Co. Va</u>	
12. CITIZEN OF WHAT COUNTRY: <u>USA</u>							
13. FATHER'S NAME: <u>John Small</u>				14. MOTHER'S MAIDEN NAME: <u>Nora Chandler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS: <u>Mrs Norman Davis, Pocomoke, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cancer Liver</u>							
DUE TO							
ANTECEDENT CAUSE (B) <u>ascites</u>							
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Chronic emphysema</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19A. DATE OF OPERATION: <u></u>				19B. MAJOR FINDINGS OF OPERATION <u></u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>9/27</u> , 19 <u>55</u> , to <u>9/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/27</u> , 19 <u>55</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>Salisbury Md</u>		DATE SIGNED <u>9/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Edgehill</u>		LOCATION (City, town, or county) (State) <u>Pocomoke Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-27-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>		24. FUNERAL DIRECTOR <u>Robert D. [Signature]</u>		ADDRESS <u>Pocomoke Va</u>	

SEP 10 1961

SEP 10 1961

SEP 10 1961

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VII A15C 1-53 10M

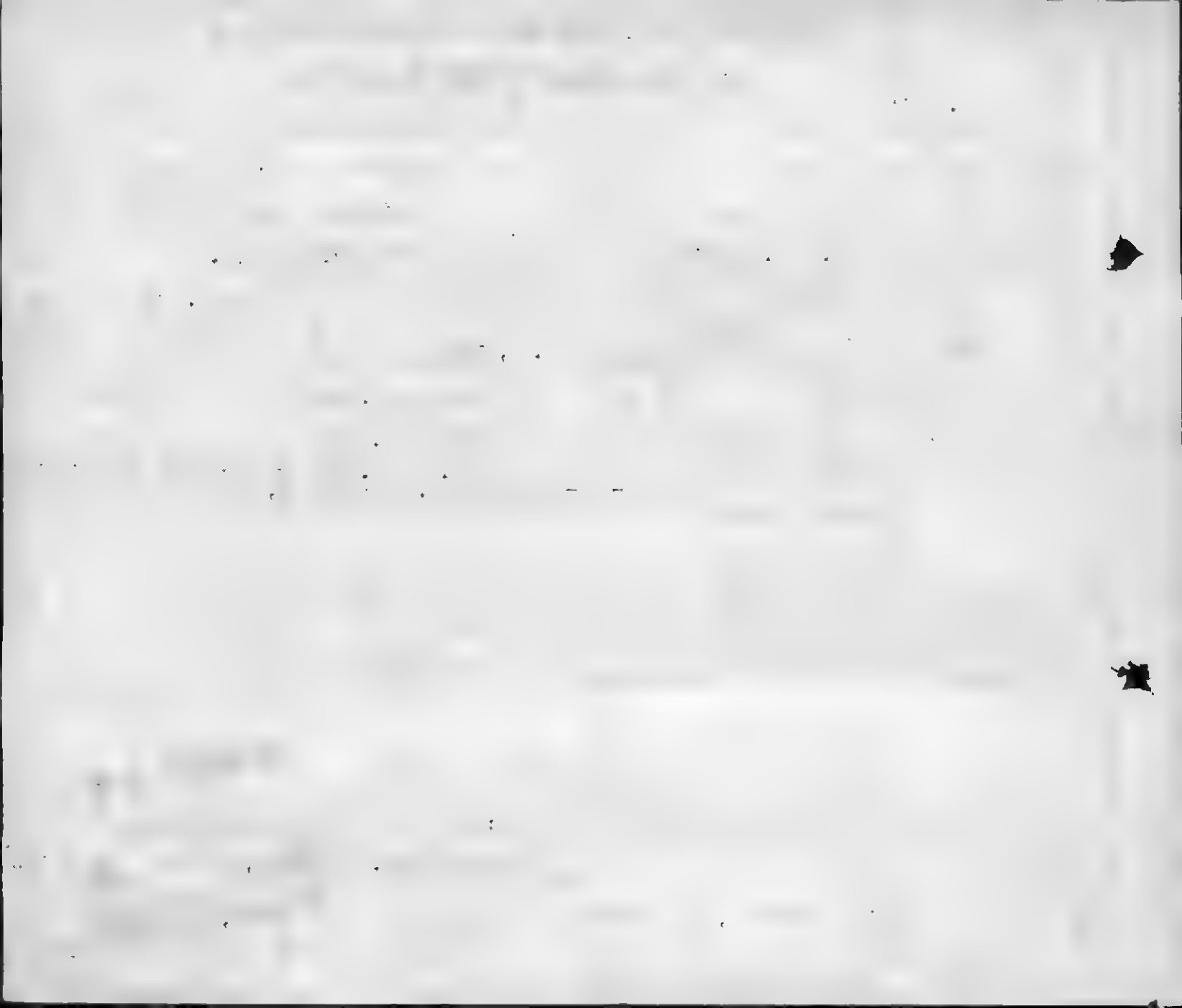
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9204
Dr. Smith

CERTIFICATE OF DEATH

09223
Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 417 Priscilla St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE last birthday	
(First) AUDREY (Middle) IDA (Last) WILLEY				(Month) SEPT. (Day) 19 (Year) th 19 55			
6. SEX Female	7. COLOR OR RACE White	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	9. DATE OF BIRTH Jan. 5, 1916	10. AGE last birthday 39 yrs.	11. IF UNDER 1 YEAR Months 8 Days 14 Hours Min. 	12. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Horace Thomas Pennewell				14. MOTHER'S MAIDEN NAME Bessie E. Pusey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 218 -20 -8186		17. INFORMANT'S ADDRESS Mr. Roy E. Willey (Husband) 417 Priscilla St. Salisbury, Maryland			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pneumonia							
ANTECEDENT CAUSE(S) DUE TO (B) Ediphenoid carcinoma of cervix - Stage IV							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 19, 1955 to Sept. 19, 1955 , that I last saw the deceased alive on Sept. 19, 1955 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. W. Smith				ADDRESS (Street, city, town, state) 706 Camden Ave. Salisbury, Maryland			
DATE Sept. 22, 1955				DATE SIGNED Sept. 21, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 22, 1955		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR Mary H. Holloway		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician please write the names of death clearly and legibly.

Dr. Earl Royer (Med Exam)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 09221

No. 332

I. PLACE OF DEATH:

COUNTY **Wicomico** MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) **Salisbury** LENGTH OF STAY (in this place)HOSPITAL OR INSTITUTION OR STREET ADDRESS **Pen. Gen. Hospital**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Wicomico**CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN **Salisbury**STREET ADDRESS (If rural, give location) **118 East Locust St.**3. NAME OF DECEASED: (First) (Middle) (Last)
(Type or Print) **JAMES LITTLETON WILLIAMS**

5. SEX:

Male

6. COLOR OR RACE:

White7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **Married**

8. DATE OF BIRTH:

Dec. 16, 19004. DATE OF DEATH (Month) (Day) (Year)
Sept. 22 19 559. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
yrs. **54** Months **9** Days **6** Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) **Truck Driver**10b. KIND OF BUSINESS OR INDUSTRY: **Moving and Storage Co.**11. BIRTHPLACE (State or foreign country): **Salisbury, Maryland**12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME:

John Littleton Williams

14. MOTHER'S MAIDEN NAME:

Millie Horner15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
Unk

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mrs. Reba R. Williams (Wife) 118 East Locust St. Salisbury, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a)..... **Coronary occlusion**.....

DUE TO

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH
Sudden

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?
Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. 21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

*Earl Royer*CHIEF MEDICAL EXAMINER ☐ DATE SIGNED
DEPUTY MEDICAL EXAMINER ☒ **Sept. 22 1955**
ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

Burial Sept. 25, 1955**Wicomico Memorial Park****Salisbury, Maryland**

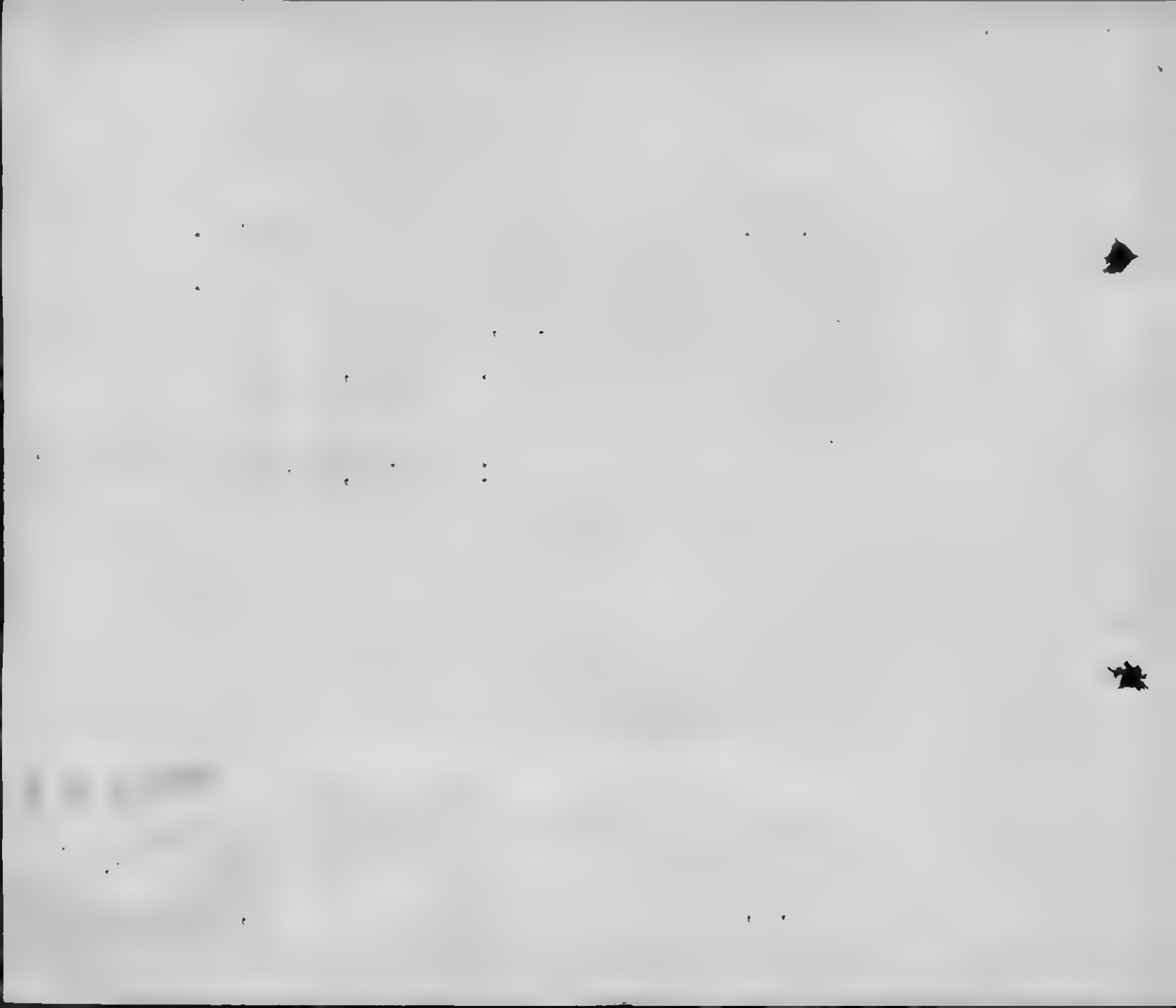
DATE RECD BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

REC 23-55*Mary W. Holloway***HOLLOWAY & COMPANY SALISBURY MARYLAND**



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9213

CERTIFICATE OF DEATH

09224

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Hebron		80 Yrs.		TOWN Hebron		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10 Main St.,				Main St.,			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) CORA (Middle) VERLIN (Last) WILSON				(Month) 9 (Day) 3 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	Mar. 25, 1875	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Wife		Own Home		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Horatie Nelson				Sally Jane Hastings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		219-34-0840		Dr. Thomas N. Wilson, Baltimore, Md.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				10. MEDICAL CERTIFICATION			
420.0				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A)				Coronary artery (sclerosis) heart disease & failure			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/1 , 19 55 , to 9/3 , 19 55 , that I last saw the deceased alive on 9/3 , 19 55 , and that death occurred at 1 P. M., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Ernest N. Larson M.D.				Delmar, Del 9/3/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9/5/55		Hebron Cemetery		Hebron, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Sept. 7, 1955		Mary H. Holloway		Norman T. Baker		The Hill & Johnson Co. Salisbury, Md.	

CERTIFICATE OF DEATH

1955

NAME OF DECEASED: [illegible]
RESIDENCE: [illegible]
DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]
SEX: [illegible]

EDUCATION: [illegible]
OCCUPATION: [illegible]

DATE OF MARRIAGE: [illegible]
NAME OF SPOUSE: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]

BUREAU V. S.

SEP 2 1955

RECEIVED

9203

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Princess Ann, Rt #1, 191-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>P.O. Box 235</u>			
3. NAME OF DECEASED: (First) <u>Edith</u> (Middle) <u>L.</u> (Last) <u>Wilson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>September 20 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		8. DATE OF BIRTH: <u>Feb. 10, 1882</u>		9. AGE last birthday <u>73</u> yrs.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Leonard Marlow</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Wetzel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>				16. SOCIAL SECURITY NO.: <u></u>			
17. INFORMANT & ADDRESS: <u>Mrs Robert Buller, Princess Anne</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						1 Day	
ANTECEDENT CAUSE (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-19</u> , 1955, to <u>9-20</u> , 1955, that I last saw the deceased alive on <u>9-19</u> , 1955, and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>		M.D. <u>Salisbury, Md.</u>		DATE SIGNED <u>9-20-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>9-22-55</u>		<u>Asbury Cemetery</u>		<u>Mt Vernon, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>9-21-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holleray</u>		24. FUNERAL DIRECTOR <u>James Henman</u>		ADDRESS <u>Princess Anne, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 28 1955

RECEIVED